



**American Hospital  
Association**

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September 1, 2006

The Honorable William Frist, M.D.  
United States Senate  
509 Hart Senate Office Building  
Washington, DC 20510

Dear Senator Frist:

On behalf of our 4,800 member hospitals, health care systems and other health care organizations, and our 35,000 individual members, the American Hospital Association (AHA) appreciates your interest in and support for advancing the use of health information technology (IT). Hospitals are committed to adopting IT to improve the safety and quality of patient care and enhance the efficiency of our health care system as a whole.

As you enter conference discussions, we urge you to consider several issues of critical concern for hospitals, including:

- funding for IT adoption;
- developing realistic standards that can be implemented;
- decreasing the legal barriers that prevent hospitals from sharing IT resources with physicians;
- streamlining privacy laws; and
- developing ways to accurately match patients with their medical records.

## **FUNDING**

Additional financing will be needed to accelerate hospital IT adoption and avoid creating a system where some health care organizations realize the benefits of IT while others do not. The adoption costs of computerized provider order entry (CPOE) and electronic health records (EHRs) – two of the most common health IT applications – measure in the tens, if not hundreds, of millions of dollars per facility, and that estimate does not reflect ongoing maintenance costs.

Not all hospitals can access this level of capital. For smaller facilities, the significant investment needed to purchase and implement IT systems can overwhelm their capital budgets. In fact, safety-net and financially strapped organizations may not be able to raise the necessary capital – a recent report from Moody's warned that these organizations in particular are at risk of falling



behind in IT development, which could put them at a comparative disadvantage.

Furthermore, while some organizations have realized improvements in patient safety and quality as a result of their IT investments, few have been able to measure a financial return on their investments. An AHA survey of hospital IT use indicates that average capital spending on IT accounts for 15 percent of capital expenses, while ongoing IT costs account for an average of 2 percent of operating expenses. As noted in a recent RAND Corporation study, the financial benefits of health IT typically accrue to payers, employers and other purchasers of care through decreased lengths of stay and fewer admissions – not to the hospitals that purchased the systems. Indeed, some benefits, such as fewer admissions, actually result in lower revenues for hospitals. As major beneficiaries of health IT, employers and payers (including the federal government) must share in the costs of IT investment.

The AHA supports financing policies that reward both innovators who have already made investments in IT and those who have yet to invest. Given that clinical IT investments represent new costs to hospitals and do not have an obvious return on investment, IT funding mechanisms for hospitals cannot be budget neutral. A combination of the following three financing approaches would provide tremendous incentives for IT adoption by the hospital field and allow the U.S. to realize the benefits of a “wired” health care system:

- **A one percent payment adjustment under Medicare** for hospitals using quality-enhancing, clinical IT, such as CPOE with decision support, would acknowledge that IT adoption results in elevated ongoing operating costs. While the payments would not completely cover those costs, a permanent source of guaranteed funds would provide an incentive for adoption.
- **Government-guaranteed, low-interest loans** to finance the initial acquisition and implementation of IT systems for providers willing to invest in certain quality-enhancing, clinical IT.
- **Federal grants** for a select group of facilities, such as small and rural hospitals with no access to debt financing, would ensure that all Americans have access to hospitals with the best clinical IT systems.

In addition, grants for health information exchange projects, also known as regional health information organizations, would encourage IT adoption. These organizations, which bring together multiple stakeholders to develop processes for sharing health information within a community, aim to make information on a patient available at the time care is provided, regardless of where the information originated (for example, an emergency department physician would be able to access a patient’s medication history or view the results of lab tests ordered by a primary care physician). Grants would provide seed funding to develop the governance and technical structures these organizations need to move forward.

Funding for health IT must be flexible. The market for health IT products is evolving; similarly, the development of health IT standards and certification standards for IT products are in their infancy. Therefore, it is premature to make financing contingent on the use of specific standards or products. As these processes develop, such conditions may be possible. However, even then,

sufficient time (for example, 24 months) must be allotted for providers to understand the new standards, incorporate them into project planning and work with vendors to ensure they are incorporated into products that are implemented.

## **STANDARDS**

Interoperability among health IT systems is key to realizing the full promise of the technology. To achieve interoperability, standards are needed for the vocabulary, content and messaging of information so that data from one system can be incorporated seamlessly into another. Today, hospitals frequently find that the various IT systems within their own facilities cannot work together without expensive patches and interfaces, let alone exchange data with other organizations.

Given health care's complexity, standards are needed in many different areas. Standards-setting organizations already have developed many different standards, with multiple choices in some areas. For example, LOINC is standard vocabulary when describing laboratory values, DICOM is a standard for transmitting digital images and SNOMED provides a vocabulary for medical practice. However, in some areas, such as clinical documentation, no standards exist. Establishing the standards to be used will require collaboration and a private-public partnership that prioritizes where standards are needed, follows a consensus-building process to determine which standards to adopt and ensures that they can be made operational.

Setting standards requires a realistic, multi-step adoption timeline. First, standards to be used by all segments of the health care field must be identified and agreed upon. Second, the standards must be sufficiently developed and supported with adequate implementation guidance to ensure compatible implementations across organizations, including pilot-testing proposed standards. Third, health care organizations must implement the standards. This requires providing sufficient and reasonable timelines for implementation in diverse settings prior to final adoption. Each step is crucial to achieving interoperability.

## **ICD-10**

One standard that must be agreed upon is the coding system used for diagnoses and inpatient procedures. The AHA supports moving to the International Classification of Diseases, Version 10 (ICD-10) as soon as possible, and no later than October 1, 2010. In 2003, the National Commission on Vital and Health Statistics recommended this move because the current system, ICD-9-CM, cannot accommodate the dramatic advances in medicine that have occurred since its inception in the 1970s. ICD-10 is needed to improve the quality of health information and support interoperable EHRs that can accurately summarize and report data.

## **LEGAL BARRIERS**

Legislation also should provide clarity regarding federal fraud and abuse laws. The physician self-referral – or so-called “Stark” – laws, the anti-kickback statute and the civil monetary penalties (CMP) laws should be amended to allow hospitals to provide hardware, software and

technical assistance to physicians to facilitate the efficient sharing of medical information and enhance the quality of patient care. Not all hospitals are in a position to provide IT resources to physicians in their communities, but those that are currently are prohibited from doing so, and the penalties for violating these laws are severe. These laws constitute a significant barrier to greater IT adoption, as noted by the Government Accountability Office, the Medicare Payment Advisory Commission, the RAND study and others.

Efforts to alleviate these legal barriers should not be based on adherence to standards for interoperability that do not yet exist, or a certification process that is in its infancy. However, the recently released final Stark and anti-kickback rules include such criteria, as well as other limitations, including a prohibition against donating hardware and a requirement that all donated software include e-prescribing capabilities. Consequently, the rules may not provide sufficient flexibility for hospitals and physicians to work together to develop health IT infrastructure.

The AHA supports changes to the Stark, anti-kickback and CMP laws to allow IT resources to be shared. We also strongly support a prohibition against physician self-referral to new limited-service facilities, as well as anti-trust legislation.

## **PRIVACY**

Hospitals are committed to protecting the privacy of patients' health information. Historically, hospitals have worked diligently to ensure the security of personal health information, and continue to do so under the provisions of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA). But they must be vigilant and regularly maintain and upgrade their information systems. The multiplicity of privacy rules from state and local governments, accrediting bodies and other organizations laid atop HIPAA requirements makes compliance difficult and can interfere with patient care. Simply laying out all of the relevant state, federal and other rules can be a monumental task, let alone determining how to comply when the rules are in conflict. A single set of privacy rules, based on HIPAA, is needed to facilitate IT adoption and use, ensure access by health care providers to needed information at the point of care, and allow patients and families to share information about themselves with their care providers.

## **MATCHING PATIENTS TO THEIR MEDICAL RECORDS**

If providers are to share information across settings, they will need a common, accurate method for matching patients to their health records. In order to make clinical decisions based on the information contained in EHRs, providers must be certain that the records they retrieve belong to the patient they are treating. Given the potential serious consequences of a false match (e.g., a patient is given a medication to which he or she is allergic), it is important to develop a process for accurately matching patients to their records. Currently, each provider and local information exchange effort is responsible for finding a way to match patients to their records. This can be a significant burden and limits the ability to share data among facilities.

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In conclusion, we thank you for your leadership on health IT issues and look forward to working with you and your staff as you undertake conference discussions. If you have any questions, please contact Kristin Welsh at (202) 626-2322 or Sohini Jindal at (202) 626-2677.

Sincerely,

Rick Pollack  
Executive Vice President