American Hospital
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December 19, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1601-P
P.O. Box 8013
Baltimore, MD 21244-1850

Jacob Reider, M.D.
National Coordinator for Health Information
Technology (Acting)
Department of Health and Human Services
200 Independence Avenue, S.W.
Suite 729-D
Washington, DC 20201

Dear Ms. Tavenner and Dr. Reider:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, I write to express significant concerns about the timelines for the adoption of the 2014 Edition Certified Electronic Health Record (EHR) and Meaningful Use requirements for fiscal year (FY) 2014 under the Medicare and Medicaid EHR Incentive Programs. As you know, hospitals are very supportive of the long-term goals of the Meaningful Use program, but the pace and scope of change are simply too much in the near term to support a safe and orderly transition, particularly given the concurrent move to ICD-10.

**The AHA asks that the Department of Health and Human Services (HHS) extend the regulatory timelines for 2014 and allow all providers greater flexibility in Stage 2. Specifically, all hospitals and physicians should have the option to make the transition to the 2014 Edition Certified EHR and the Stage 2 requirements (or the revised Stage 1 requirements, as applicable) over the course of 2014 or 2015. In addition, the Stage 2 requirements should be more flexible, in recognition that many of the mandated objectives − such as "transitions of care" and the patient portal to support "view, download and transmit" of data − are new and make providers' success dependent on the actions of others.**

Hospitals are reliant on their vendor partners to deliver certified EHR technology. As described below, hospitals are facing challenges obtaining and installing certified EHRs that work as promised, making the current timelines unrealistic. The real-world issues facing hospitals are, however, solvable given time. We believe that extending the regulatory timelines for 2014 and allowing all providers greater flexibility in Stage 2 will ensure a successful program.

## TOO MUCH, TOO FAST

The meaningful use program has provided a common direction for adoption of EHRs, and the incentives have been helpful to those who have received them. However, the pace and scope of change have outstripped the ability of vendors to support hospitals, and for hospitals to manage the transition to the 2014 Edition Certified EHR in a safe and orderly manner. This is especially true given the concurrent transition to ICD-10. Under this transition, all providers, payers and clearing houses must change all of their information systems – administrative and clinical − to conform to the ICD-10 standards on Oct. 1, 2014. Your agencies' Dec. 6 announcement of the shift in the start of Stage 3 of Meaningful Use from 2016 to 2017 was helpful in acknowledging future timing issues, but does not address the immediate concerns of FY 2014, which began on Oct. 1, 2013.

Hospitals are reliant on their vendors to deliver the necessary software to meet meaningful use, and all hospitals must upgrade to the 2014 Edition Certified EHR in the fiscal year that started on Oct. 1, 2013. As the first quarter of the fiscal year closes, our members are increasingly concerned that vendors do not have sufficient bandwidth to support them in this transition. Like providers, EHR vendors have been operating under regulatory timelines that ask for too much, too fast. While many vendors have received certification for at least a "basic EHR," at least one vendor that supports many rural hospitals has yet to get any 2014 Edition products certified. Furthermore, the base EHR is necessary, but not sufficient, for a provider to meet Meaningful Use, and covers less than half of the functions that hospitals must report on. For example, a base EHR has not been certified for a patient portal that supports viewing, downloading and transmitting data or any of the public health reporting objectives.

Hospitals are finding that, while base systems have been certified, they are not being delivered in a timely manner, vendors are uncovering errors in their software that must be patched, and many essential components are either not available or not working as promised. Once software is received, hospitals must still take many steps to install systems, train thousands of clinicians and staff members, and change how the work of caring for patients is done to come into compliance with the Meaningful Use requirements.

Given these challenges, those ready to move ahead this fiscal year should be allowed to do so, while those needing additional time to get it right should be afforded that time. Flexibility in the Stage 2 requirements would ensure that hospitals can build out the necessary processes and relationships for new and important objectives that also require actions by others − such as "transitions of care" or "view, download, and transmit." Flexibility also is needed because under the current "all or nothing" compliance regimen, hospitals and physicians missing a single portion of a single objective by a single percentage point will fail Meaningful Use and be subject to subsequent and significant payment penalties, in addition to missed incentive payments. The "all or nothing" approach is simply unfair.

To capture real-time experience with the roll-out of the 2014 Edition Certified EHR technology, the AHA received input from a dozen hospitals and health systems representing the experience

of almost 500 hospitals across the nation. These leaders in implementing health information technology (IT) to improve patient care have experienced the following challenges in adopting the 2014 Edition Certified EHR (see attachment):

- The majority of hospitals have not yet received from their vendors all of the needed 2014 Edition Certified EHR components that have been validated to work.
- Almost all hospitals have found that the certified components delivered by vendors so far did not work "out of the box."
- Nearly half of the hospitals have found that the majority of the technology received from vendors to date has required additional software code upgrades by the vendor to make the technology functional. Nearly one out of five hospitals has found that all of the technology received to date needed upgrades and fixes.
- The majority of hospitals are missing modules that support objectives of Meaningful Use that are new in the 2014 Edition Certified EHRs because the vendor has not delivered them, or has announced a significant fix that has yet to be delivered. Hospitals are most likely to be missing the "Direct" protocol exchange modules (68 percent); the patient portal to support viewing, downloading and transmitting data (63 percent); and the "transitions of care" functionality, including the continuity of care document (62 percent).
- If current timelines remain, 40 percent of hospitals are at risk of failing to meet meaningful use in FY 2014.

Receiving software is just the first step in the EHR installation process. Our advanced health IT hospital leaders indicated that, absent regulatory requirements, changing EHRs at the scale of the 2014 Edition upgrade takes 19 months to efficiently and safely move from having the software to being able to attest to the next stage of Meaningful Use. That includes:

- three months for software assessment;
- eight months for installation, implementation and training across the thousands of clinicians and staff that use these systems to support care;
- five months to build up to the performance metrics required by meaningful use; and
- a three-month reporting period.

## INFRASTRUCTURE LAGGING

In addition to challenges with the 2014 Edition Certified EHR software upgrade, hospitals have found that the infrastructure to support the level of health information exchange in Stage 2 is not ready. Although progress is being made, the nation does not yet have a fully functioning network of health information exchanges. Hospitals generally do not have access to provider directories that will allow them to identify the "Direct" protocol address of other providers.

Many logical recipients of a hospital's transition of care summary, such as a nursing home or rehabilitation facility, do not have the capacity to receive one. Health departments across the nation are in various stages of being able to receive the required public health information according to the standards published, but most are not able to accommodate the variety and volume of transmissions hospitals are required to make.

In the face of these problems, hospitals are rightfully concerned about their ability to meet the existing timelines and requirements, which are simply not realistic. Given this situation, we fear that small and rural facilities – which are often at the end of the vendor queue – are at particular risk of falling even further behind. Most importantly, rushing to implement without sufficient testing and training is unsafe and risks unintended negative consequences. Hospitals will prioritize patient safety over regulatory compliance, but should not be asked to do so.


## CONCLUSION

Hospitals support the end goals of the EHR incentive programs and are working diligently to implement this technology. We fear, however, that maintaining the existing timelines and inflexible Stage 2 requirements would be counter-productive to achieving our shared goals of care transformation that is supported by safe and effective information systems.

Thank you for your consideration of these important issues. If you have any questions, please do not hesitate to contact me or Chantal Worzala, director of policy, at cworzala@aha.org or (202) 262-2313.

Sincerely,

/s/

Rick Pollack
Executive Vice President


Cc: J. Blum, R. Tagalicod, CMS
    T. Gronniger, White House Domestic Policy Council
    C. Dawe, National Economic Council

**Attachment:**
**Hospital Experience Implementing 2014 Edition Certified EHRs**

To capture real-time experience with the roll-out of the 2014 Edition Certified EHR technology, the AHA received input from a dozen hospitals and health systems representing the experience of almost 500 hospitals across the nation.[i] The challenges encountered by these leaders in implementing health information technology (IT) to improve patient care are captured in the charts below.

## Chart 1: Most hospitals have not yet received all necessary components of the 2014 Edition certified EHR from their vendors.

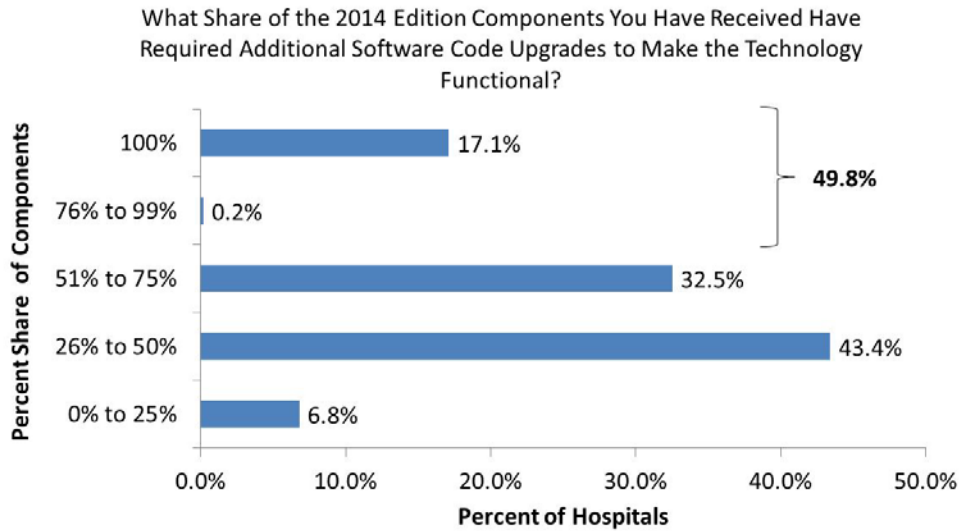Has Your Hospital Received All of the Needed 2014 Edition Certified EHR Components?

| Yes, 39.9% | No, 60.1% |
|---|---|

## Chart 2: Very few hospitals have found their 2014-certified EHRs work "out of the box."

Did all of the 2014 Edition Certified Components Your Hospital Received to Date Work Out of the Box?

No, 98.7%

Yes, 1.3%
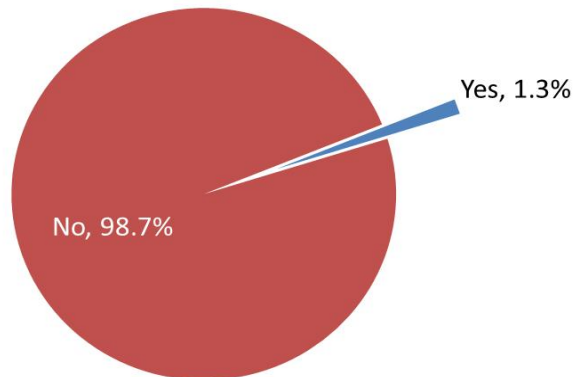
## Chart 3: Almost half of hospitals report that most 2014 Edition certified technology components require fixes after delivery.

What Share of the 2014 Edition Components You Have Received Have Required Additional Software Code Upgrades to Make the Technology Functional?



## Chart 4: Many hospitals have yet to receive final 2014 Edition software modules from their vendors to support key Stage 2 objectives.

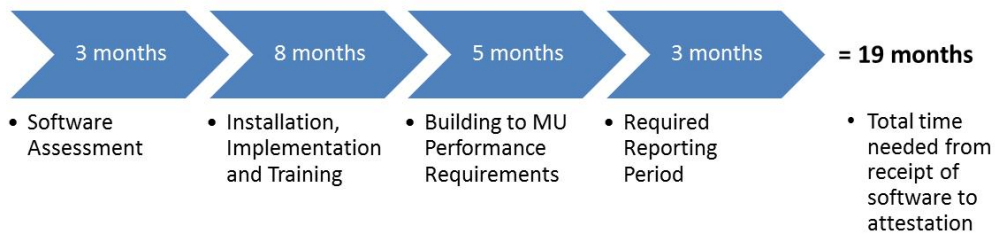How Many of Your Hospitals are Missing the Following Modules from the 2014 Edition EHR Technology?
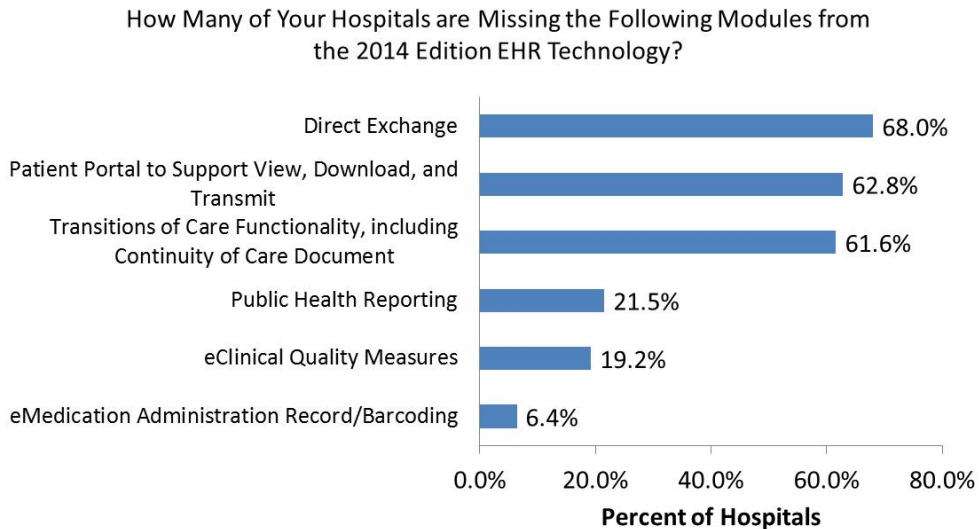
## Chart 5: Many hospitals are at risk of missing meaningful use in FY 2014 given current challenges and timelines.

If the Current MU Timelines and Requirements Stay the Same, How Many of Your Hospitals Are At Risk of Missing the Deadline to Meet Program Requirements in FY 2014?

At-Risk, 40.3%

Not At-Risk, 59.7%
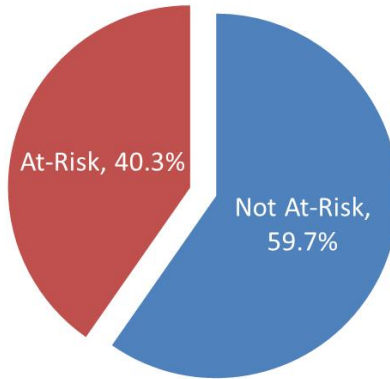
## Chart 6: Hospitals estimate that it takes 19 months, on average, to properly and safely implement their 2014 Edition Certified EHR systems.

What Are the Appropriate Timelines (in months) for the Following Steps in an Efficient and Safe 2014 Edition EHR Attestation Process?

| 3 months | 8 months | 5 months | 3 months | = 19 months |
|---|---|---|---|---|
| • Software Assessment | • Installation, Implementation and Training | • Building to MU Performance Requirements | • Required Reporting Period | • Total time needed from receipt of software to attestation |

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