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**Statement
of the
American Hospital Association
to the
U.S. Senate
Committee on Health, Education, Labor and Pensions**

**“America’s Health IT Transformation:
Translating the Promise of Electronic Health Records into Better Care”**

March 17, 2015

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment for the record in support of harnessing the power of health information technology (IT) to improve health and health care.

HEALTH IT IS ESSENTIAL FOR THE CARE SYSTEM OF THE FUTURE

The AHA has long advocated for expanding the use of health IT, specifically the rapid adoption of electronic health records (EHRs) and national interoperability standards. As we continue to transform health care delivery and payment systems to enhance accountability, better coordinate care and engage individuals in their own health, the importance of a strong health IT infrastructure becomes increasingly clear. Shared health information will allow clinicians and patients to have the data they need at their fingertips to promote health and make the most informed decisions about treatments. Bringing together information from across settings creates the ability to better manage individual and population health. The upcoming transition to the ICD-10 coding system on Oct. 1, 2015 also supports efforts to transform care by providing better data to monitor resource utilization; improve clinical, financial and administrative performance; and track public health risks. While deploying these technologies to make advancements, hospitals are mindful of the need to be ever vigilant in protecting the security of increasingly large stores of electronic information.



While health IT tools are essential for building the care system of the future, they can be expensive and unwieldy, and do not yet support the necessary level of easy information sharing expected by consumers. Policy actions are needed to give providers greater flexibility in deploying EHRs; hold vendors accountable for designing and marketing safe, interoperable products; and provide certainty with respect to the transition to ICD-10.

HOSPITALS ARE USING HEALTH IT TO IMPROVE HEALTH AND HEALTH CARE

Hospitals have made great strides in implementing EHRs over the past five years. Indeed, the most recent AHA survey data show that, by 2013, 59 percent of hospitals had at least a basic EHR in place – four times the share in 2010. In general, small and critical access hospitals lag behind their larger, urban counterparts in health IT adoption (Adler-Milstein, et al. 2014). In addition to EHRs, hospitals increasingly are adopting telehealth, remote monitoring and data analytics solutions to expand the availability of care and improve coordination across care settings.

If designed and implemented well, EHRs can support improvements in care by ensuring the appropriate information is available for clinical decision-making and offering clinical decision-support tools. In the long term, EHRs also could streamline and reduce the burden of quality reporting and support continuous hospital quality improvement. Indeed, we have seen significant examples of technology enhancing safety, such as the adoption of bar-code medication administration to help ensure patients get the right medications in the right dose at the right time.

However, any new technology can also cause unintended disruptions. It is the shared responsibility of health IT vendors, clinicians, health care organizations and federal agencies to ensure that health IT systems are designed, implemented and used to mitigate harm and promote safety. These initiatives should build on existing patient safety efforts across government programs and the private sector and address health IT as one of many factors affecting safety, rather than as a topic on its own. On a policy level, the AHA wants to ensure that federal safety oversight for health IT is nimble, but sufficient to protect patient safety and ensure that hospitals and other providers are not exposed to liability from unsafe products.

CONTINUED PROGRESS REQUIRES GETTING MEANINGFUL USE RIGHT

Hospitals need more flexibility under the EHR meaningful use program to make progress toward the health systems of the future.

A key driver of EHR adoption has been the Medicare and Medicaid EHR Incentive Programs, which provide positive incentives for “meaningful use” of EHRs that have been certified through a program established by the Office of the National Coordinator for Health Information Technology (ONC), followed by Medicare penalties for hospitals and physicians that do not meet the requirements.

According to the Centers for Medicare & Medicaid Services (CMS), over the past five years, a total of \$18 billion in incentive payments has been made to hospitals, with \$10 billion paid to physicians (CMS 2015). The last Medicare incentives will be paid in 2016. Penalties under the program began in 2015, and will apply to some hospitals and more than half of Medicare physicians. Medicare penalties continue in future years without sunset. Critical access hospitals also face the loss of incentives and receive no considerations for their size and unique circumstances.

While the incentives were a welcome offset to the large costs of purchasing and installing EHRs, AHA members report that, on average, they covered only 10 percent of the costs incurred. Indeed, based on data from the AHA annual survey, we estimate that between 2010 and 2013 hospitals spent an average of \$47 billion *per year* on IT operating and capital costs. Data are not yet available for 2014, when hospitals and physicians were required to upgrade their systems to new versions of certified EHRs.

The meaningful use program has spurred remarkable growth in EHR adoption by hospitals. However, it has become a highly proscriptive program that holds hospitals accountable for events outside of their control. For example, to meet the transitions of care requirement, a hospital must find other providers ready to receive information in the manner required by the government. Yet post-acute care providers are not part of the meaningful use program, and half of physicians have yet to meet meaningful use.

Given the complexities of the program, and the delays in delivery of certified EHRs from vendors, hospitals and other providers have experienced challenges in meeting the rigid requirements of the program in order to avoid penalties. Even with last-minute flexibility provided by the administration in fiscal year (FY) 2014, the AHA is concerned that the fast pace and broad scope of the EHR incentive programs continue to pose significant challenges to hospitals and physicians, with greater challenges often faced by small and rural facilities. We believe any future requirements, including the upcoming Stage 3 rule should be informed by field experience and carefully weigh the benefits of new requirements against the expected costs of compliance.

The AHA believes that the following changes are needed to fix the EHR Incentive Programs:

- 1. Allow adequate time for hospitals and other providers to transition to Stage 2.** A reporting period of one-quarter in FY 2015 (rather than an entire year) would keep hospitals on track at a pace that supports safe implementation. It also would allow hospitals to optimize new technology for clinical care and build information-sharing networks. While the administration has signaled it intends to provide this flexibility, it remains critical that it finalize this flexibility. Bipartisan legislation has been introduced in the U.S. House of Representatives to provide this needed flexibility. However, more needs to be done to make it a reality, now that we are almost halfway through FY 2015.
- 2. Remove specific requirements that hold hospitals accountable for the actions of others, but expect the technology to be in place.** For example, a hospital would need to

have a patient portal, but would not need to meet a specific requirement on the percentage of patients who use it, as is currently required.

3. **Wait until a sufficient number of hospitals and physicians have met Stage 2 before setting the start date or requirements for Stage 3.** This is a matter of common sense when so few have met the Stage 2 requirements.

CONTINUED PROGRESS REQUIRES INFORMATION SHARING

A key motivator of federal involvement in the health IT space was the recognition that sharing of health information would improve the quality and safety of care, while reducing overall costs of care. For example, the results of an imaging test done by one health care provider could be shared with the specialist consulting on the case, rather than having the test repeated. Or, an emergency room physician could access information about a trauma patient from his or her primary care provider to ensure she takes into account the patient's full medical history. Past estimates by the RAND Corporation suggested that use of interoperable systems by hospitals alone could result in net savings of nearly \$371 billion over 15 years, while also improving the safety and quality of care (Hillestad, et al. 2005).

At the same time, hospitals and health systems face an increasing confluence of pressures to share information to support care, but need the technical capabilities and infrastructure to do so. These include imperatives to share information across the continuum of care in support of reducing readmissions and adopting new models of care, as well as growing expectations from consumers that their information will follow them as they move through the health system. This includes settings as diverse as individual provider offices, general and specialty hospitals, skilled nursing facilities and other post-acute care providers, and behavioral health providers, among others. In addition, individuals and their family members or other caregivers are coming to expect electronic access to such information.

Furthermore, new payment models, such as accountable care organizations, bundling initiatives and capitation arrangements, require a better understanding of where patients are receiving care, and what care is being provided. As announced by Department of Health and Human Services (HHS) Secretary Sylvia Burwell in January 2015, Medicare now has specific goals for moving fee-for-service payments from volume to value by 2018, including tying 50 percent of payments to alternative payment models and 90 percent of payments to some type of quality or value metrics. In addition, patients and payers increasingly are interested in having access to the data held by health care entities to increase patient engagement and enhance transparency.

These existing market pressures already are motivating information sharing, and will continue to do so in the coming years as payment systems move from volume to value and consumer demand increases. Adding additional policy drivers aimed at encouraging providers to share health information would be unnecessary, and could prove counter-productive if they become overly prescriptive or contradict the larger set of incentives.

LACK OF INTEROPERABILITY PUTS PROGRESS IN PERIL

Unfortunately, the certified EHRs hospitals were mandated to purchase under the EHR incentive programs do not meet the mark when it comes to sharing information to improve care and support new models of care. The ability of these expensive systems to support the sharing of information across systems within a hospital or across care settings remains limited. Hospitals are finding that they still cannot share data with others outside their organization without significant work and expense. This is true whether providers are using the same vendor platform or different ones.

Given that hospitals and other providers are required to use certified EHRs, we believe policy changes are needed to hold vendors accountable for the design and marketing of interoperable products. AHA members widely report that the EHRs they have purchased over the past five years do not easily share information, and the cost and complexity of the interfaces vendors sell to create work-around solutions are simply not sustainable. Similarly, the new transaction fees being imposed for information exchange also present an unsustainable model for widespread sharing of health information. At a minimum, ONC must fix the certification program for EHRs so that vendor products go through rigorous testing in a way that reflects real-world conditions. ONC also should provide more oversight of vendors, including developing transparency metrics on vendor performance parallel to the many quality reporting programs HHS has implemented for providers, such as *Hospital Compare*.

Beyond certification, federal support of widely available conformance testing would improve the ability of vendors and providers to create solutions that work. It is only by thorough and widely available testing that true interoperability can be ascertained. In the EHR space, testing should include both the EHR itself, as well as interfaces to ancillary systems (such as laboratory information systems) that connect to EHRs. Test beds should be widely available to developers and end-users of EHRs on an ongoing basis to support development, certification and assessment of implementations. Testing requirements should be developed in consultation with providers – the end-users of the products tested.

Further, the issue of how to match patients with their medical records remains unresolved despite the continued push for interoperability on a national scale. The need to resolve this problem is urgent, and the AHA recommends the creation of a nationally unique identifier system to connect records so that hospitals and physicians have the best information available when providing care for each patient. Such a system would facilitate efforts to increase the safety and quality of care given to patients and reduce wasteful spending by hospitals and other providers to use less-effective and duplicative approaches to identify patients and match records.

ICD-10 SUPPORTS FUTURE MODELS OF CARE

The AHA strongly supports the Oct. 1, 2015 ICD-10 compliance date and opposes any steps to delay implementation further. In addition, a dual coding system running ICD-9 and ICD-10 codes simultaneously would be unworkable.

The AHA supports the statutory requirement that hospitals and other health care entities transition to ICD-10 because it provides needed modernization of coding and billing systems. While it entails significant effort and cost, the move to ICD-10 is important to ensure payment accuracy and deepen our understanding of health care delivery. The expanded granularity of the ICD-10 codes will allow health care providers and payers to better distinguish newer technologies and resource differences, and better analyze data to support new care models. Enhancements include the ability to differentiate surgical approaches, anatomical regions and new medical devices.

Hospitals widely report they will be ready to submit claims using ICD-10 by the scheduled implementation date of Oct. 1, 2015. In a 2015 survey of 362 hospitals conducted by the AHA, more than nine out of 10 hospitals responded that they were moderately to very confident of meeting the deadline. Further, more than 85 percent of critical access hospitals expressed confidence in their ability to report claims under ICD-10 by Oct. 1, 2015, an increase in readiness for these small, rural hospitals. Hospitals also are actively preparing their information systems, affiliated physicians and coders to make the transition possible. Ninety-eight percent of hospitals have information system upgrades underway or completed, while 88 percent are working to educate physicians.

However, hospitals need a firm commitment from Congress and the administration that Oct. 1, 2015 is the transition date so that they can plan with confidence. The one-year delay in the ICD-10 implementation date was extremely costly for hospitals and health systems, as significant investments were made to prepare for the Oct. 1, 2014 implementation date, many of which are now being duplicated. CMS estimated that the delay cost health plans, Medicare, Medicaid, hospitals and large providers between \$1.2 billion (low estimate) and \$6.9 billion (high estimate) (CMS 2014). The delay also disrupted hospital operations. Any further delay will only add costs, as existing investments will be further wasted and future costs will grow.

Some advocates for delaying ICD-10 have suggested that physicians should be able to continue coding claims with ICD-9 after Oct. 1, 2015 if they are not ready to transition. However, that approach would require payers to run dual systems. Most already have invested in systems supporting ICD-10, and reprogramming them to allow optionality would be costly. On the provider side, many hospitals support physician practices using a team of professional coders. It would be very confusing and add cost for them to code under both systems at the same time. Simply put, running ICD-9 and ICD-10 at the same time is not feasible.

KEEPING SYSTEMS SECURE

Hospitals and health systems have an obligation to keep all information systems, not just those containing protected health information, confidential and secure. The AHA has created a suite of member education tools to raise awareness of cybersecurity issues and risk management strategies (www.aha.org/cybersecurity). We will continue these efforts and work with the federal government on its priorities, such as sharing information on cyber risks. As Congress considers cybersecurity issues, it must recognize that, unlike many sectors, health care already has federal statutes and regulations governing information security. For example, the Health Insurance Portability and Accountability Act (HIPAA) regulations lay out the security

and breach notification requirements for providers and others in the health sector, accompanied by enforcement mechanisms and significant criminal and civil penalties for non-compliance.

CONCLUSION

The AHA and the hospital field appreciate your recognition of health IT as a cornerstone of the health care system of the future. Hospitals continue to make significant investments to ensure technology supports individual health and better health care, and to explore and plan for future uses of technology. We urge Congress and the administration to create a policy environment that supports these efforts and accelerates the transition to the health care system of the future.

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