American Hospital Association

Health Information Technology

Background

The national transition to more integrated and patient-centered health care increases the importance of health information technology (IT) systems that allow clinical information and decision support to be deployed and shared widely and efficiently. The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs provide incentives and penalties to encourage "meaningful use" of EHRs by hospitals and physicians.

The AHA successfully advocated for a more reasonable and flexible set of meaningful use requirements in Stage 1 of the program and a delay in the start of Stage 2 until fiscal year (FY) 2014. However, as hospitals invest capital and human resources to meet the meaningful use requirements of these programs, they are finding the regulations governing these programs to be challenging and complex. The Centers for Medicare & Medicaid Services (CMS) administers the incentive programs, while the Office of the National Coordinator for Health IT (ONC) sets the rules for certifying EHRs. The certification rules affect hospitals and physicians because they determine the criteria providers' IT systems must have in order to qualify for incentive payments, and lay out data standards that hospitals and physicians must use, such as vocabularies for recording health information and exchange standards for sharing information.

AHA View

The AHA has been a longstanding advocate for health IT, specifically the rapid adoption of EHRs and national interoperability standards. Shared health information will allow clinicians and patients to have the information they need to promote health and make the most informed decisions about treatments. But this goal will be reached only if rules promoting IT adoption are clear and reflect the real-world practicalities of implementing new technology systems.

EHR Incentive Programs. Congress meant the meaningful use incentives to be an important federal investment in harnessing the power of IT to enhance patient care. While hospitals have made great strides in implementing EHRs, in the first year of the program, only 8 percent of hospitals and 4 percent of physicians received incentive payments for achieving meaningful use, according to data from CMS.

Meaningful Use Stage 1. CMS has established confusing meaningful use rules complicated by voluminous additional guidance, as well as a challenging operational structure. The AHA continues to work with CMS to clarify requirements and reduce the burden of registering and attesting to meaningful use. We have successfully advocated to ensure that hospitals can, with permission, help their physicians sign up for the program and attest to meeting the requirements, as well as adopt more efficient, batch-reporting approaches. We also have ensured that hospitals can attest to meaningful use even if they encounter problems with the poorly specified and executed clinical quality measures required for Stage 1. We will continue to work with CMS on the implementation of incentives for critical access hospitals, particularly in the definition of allowable costs.

Meaningful Use Stage 2. CMS and ONC published proposed rules in March that increase the meaningful use requirements, particularly in the areas of sharing data with patients and other settings of care. The AHA will advocate for meaningful use Stage 2 requirements that are feasible and sensible. We are concerned that the proposed Stage 2 rules ask for too much, and we will focus on ensuring that the rules represent a true incremental change from Stage 1, that the problems with the clinical quality measures are resolved, and that the penalty phase of the rule is implemented fairly. Stage 2 must be viewed in light of the many competing demands on hospital and physician IT systems, including the movement to a new coding system for payment (ICD-10), new rules for electronic claims submission and other administrative transactions, the introduction of value-based purchasing, and additional health reform initiatives that will require calculation of quality metrics and other information system changes.

As requested by the AHA, ONC has proposed for Stage 2 to revamp some of its complex, confusing and costly certification rules. In particular, ONC proposes to change its definition of "certified EHR technology" in a way that requires hospitals and physicians to have EHR technology to support only the objectives they use to achieve their stage of meaningful use. This change will decrease the cost and burden of buying systems and make it easier to combine products from multiple vendors. The AHA will encourage ONC to initiate this change in FY 2013 – one year earlier than ONC has proposed.

The AHA believes that Stage 2 should be guided by the actual experience of implementing Stage 1. We are especially concerned about **the impact of the program on small and rural providers, and believe that the EHR incentives program should close, not widen, the existing digital divide. Data from the AHA's surveys indicate that, while hospitals as a whole saw tremendous increases in adoption of EHRs in 2011, the rate of increase was strongest among large and urban hospitals, and rural hospitals had the lowest level.** In light of the mere 8 percent of hospitals that have met meaningful use requirements for Stage 1, the AHA believes that Stage 2 of meaningful use should not start until at least 75 percent of hospitals and physicians have successfully achieved Stage 1.

The Stage 2 proposed rules also describe how CMS plans to assess penalties for those who do not meet meaningful use. By law, penalties begin in FY 2015; however, CMS proposes to base penalties on whether hospitals met the meaningful use requirements two years earlier, or 15 months earlier for those first attesting to meaningful use. The AHA strongly believes this will unfairly accelerate when hospitals must meet meaningful use to avoid penalties, and we will advocate for a fairer policy.

Multi-Campus Hospitals. In the meaningful use program, hospital systems with multiple campuses are not eligible for more than one federal incentive payment if they share a single Medicare provider number. That is, CMS will make a single incentive payment (and assess penalties) for the entire system rather than a separate payment (or penalty) for each hospital. However, each site will still incur considerable costs in implementing EHRs. The cost of implementation at each site far exceeds the purchase cost of the actual application or software, and includes hardware, workflow redesign and staff training, among other costs. **The AHA supports the *Equal Access and Parity for Multi-Campus Hospital Act* (H.R. 2500), introduced by Reps. Michael Burgess, (R-TX), Eliot Engel (D-NY), Kevin Brady (R-TX) and Charles Rangel (D-NY), which would allow individual hospital sites to separately qualify for EHR incentives.**

Eligibility for Other Care Settings. The law establishing the EHR incentive programs limited them to hospitals and physicians. **As we move toward a more integrated health care system, additional settings of care also should receive support for their transitions to EHRs.** We must ensure that all patients benefit from having their health information shared electronically across providers, including those receiving care in post-acute settings and rural health centers.

Supporting Physician Adoption of EHRs. The limited exception to the Stark law and the anti-kickback law safe harbor that permit hospitals to assist physicians in developing EHRs will expire December 31, 2013. **These regulatory provisions should be extended beyond the current expiration date. In addition, the regulation should include additional flexibility, such as allowing hospitals to share hardware or completely subsidize connectivity and software.** (Refer to the AHA issue paper "Physician Issues" for more information.)

OTHER INITIATIVES

In addition to advocating for EHR incentive programs that work, the AHA continues to work on the following health IT issues:

Health Information Exchange. ONC received $2 billion in stimulus funds to build the infrastructure to support interoperable health information exchange (HIE), but the capacity to share information is still limited. Each state received funds from the Department of Health and Human Services (HHS) to establish a state-wide HIE. **The AHA supports the goal of HIE and will work with state hospital associations to ensure that federal efforts do not unintentionally result in state-level systems that cannot be connected.** Looking forward, the AHA also will work with federal partners to ensure that efforts to establish a nationwide health information network take into account how hospitals and physicians generate, use, share and secure health information.

ICD-10 Adoption. In 2009, HHS mandated adoption of new International Classification of Diseases (ICD) standards, or ICD-10. This replacement to the outdated ICD-9 coding system was long overdue, and the AHA supports the change to ICD-10 because it provides greater precision in the classification of disease. In early April, HHS issued a proposed rule to delay the implementation for one year, until October 1, 2014. The delay is prompted at least in part by problems with implementing a new version of the HIPAA transaction standards in January that interrupted payments for some hospitals and physician offices, and by growing evidence that small providers were behind in the implementation process. The AHA supports a short delay (no more than 12 months) and recommends that HHS keep the transition for both diagnoses and procedures (ICD-10-CM and ICD-10-PCS) on the same timeline. In a recent AHA member survey assessing ICD-10 readiness, 70 percent of responding hospitals thought that a short delay in ICD-10 compliance would be helpful given the many competing initiatives, including health reform implementation and the adoption of EHRs. In addition, the AHA has launched extensive educational programs to help hospitals prepare for this significant and complex transition.

Unique Identifiers. The issue of how to match patients with their medical records remains unresolved despite the continued push for interoperability on a national scale. The AHA continues to press for a resolution, and to recommend the creation of a nationally unique identifier system to connect records and to ensure 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.

Similarly, a system of unique identifiers for medical devices would increase efficiency and add an element of transparency to the medical device industry by providing basic, standardized information on all medical devices. The Food and Drug Administration finished a pilot test of a system for unique device identifiers for medical devices and is overdue to release proposed rules on the issue. **The AHA continues to advocate for a uniform system of identification in order to streamline supply chain efficiencies, reduce costs and improve patient safety.**