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, they are finding the regulations governing these programs to be challenging and complex and the price tag of EHRs and implementation high. 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 meet in order to qualify for incentive payments, and identify 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 intended 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 two years of the program, fewer than half of all hospitals and less than one-third of critical access hospitals (CAHs) received incentive payments for achieving meaningful use, according to data from CMS. Similarly, fewer than half of eligible physicians and other professionals have met meaningful use and received incentive payments. Nevertheless, the Department of Health and Human Services (HHS) is on track to raise the bar significantly in Stage 2 of meaningful use, and is currently developing additional requirements for Stage 3.

The AHA is concerned that the fast pace and broad scope of the program pose significant challenges to hospitals and physicians and has asked HHS to fund a thorough evaluation of experience to date before finalizing Stage 3 requirements.

We are pleased CMS heeded our concerns and will delay any rulemaking on Stage 3 until 2014; however, we believe additional time is necessary.

Meaningful Use Stage 1. CMS finalized 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 for changes to CMS policies that allow CAHs to include capital lease costs as allowed expenses under the program. In addition, CMS has responded to the AHA's call to ensure that physicians providing services in outpatient departments of CAHs and billing under "Method 2" can qualify for incentives beginning in 2013. For more information, see the AHA issue paper "Small or Rural Hospitals."

Meaningful Use Stage 2. CMS and ONC published final rules in September 2012 that increase the meaningful use requirements under Stage 2, particularly in the areas of sharing data with patients and other settings of care. The AHA successfully advocated for additional flexibility in Stage 2 by allowing providers some choice of which measures to meet and a shorter reporting period in FY 2014. Nevertheless, **we are concerned that the Stage 2 rules ask for too much, too soon, and we will carefully monitor the transition from Stage 1, with particular focus on clinical quality measures (CQMs) and the penalty phase.**

The AHA strongly supports the goal of using EHRs to streamline quality reporting while increasing access to real-time information to improve care. However, hospitals will not be able to routinely report CQMs through EHRs until measure developers and vendors build e-specifications and EHRs that support efficient generation of accurate and reliable quality data. CMS and ONC included infrastructure improvements in the Stage 2 meaningful use final rule intended to address several Stage 1 data capture and reporting challenges. However, the infrastructure remains problematic and significant work is needed to improve regulatory and technical processes. The AHA will work with CMS to identify and address issues with the electronic CQMs and better harmonize quality reporting requirements across programs. For more information, see the AHA issue paper "Quality and Patient Safety."

The Stage 2 final rules also assess penalties for those who do not meet the meaningful use standards. By law, penalties begin in FY 2015; however, CMS will instead base penalties on whether hospitals met the meaningful use requirements two years earlier, or 15 months earlier for those attesting to meaningful use for the first time. The AHA strongly believes this unfairly accelerates the timeframe under which hospitals must meet meaningful use to avoid penalties.

Stage 2 also 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.

We are especially concerned about the impact of the EHR program incentives on small and rural providers. Data from the AHA's surveys indicate that, while hospitals as a field saw increases in adoption of EHRs in 2011 and 2012, the rate of increase was highest among large and urban hospitals, and lowest among rural hospitals. In light of the variability in adoption by type of hospital, **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.**

Eligibility for Other Care Settings. The law establishing 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 transitioning 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 clinics.

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 Dec. 31, 2013. **These regulatory provisions should be extended beyond the current expiration date. The regulation also should include additional flexibility, such as allowing hospitals to share hardware or completely subsidize connectivity and software.** For more information, refer to the AHA issue paper "Physicians and Non-Physician Practitioners."

Health IT Safety. The increased use of EHRs has led to an increased focus on safety issues. It is a 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. Steps to address safety 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. **The AHA supports the development of a voluntary code of conduct for EHR vendors with specific commitments to ensuring and promoting safety.** The code of conduct should make clear that vendors are responsible for safe design and product development and will support safe use of their products. In addition, the code of conduct should discourage vendors from including in their contracts indemnity clauses or non-disclosure language that limit the ability of users to identify and raise safety concerns. The code of conduct also should address other areas, such as

transparency in pricing and adherence to existing coding conventions for systems that support billing.

OTHER INITIATIVES

In addition to advocating for EHR incentive programs that achieve their intended purpose, 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 exchanges (HIEs), but the capacity to share information remains limited. Each state received funds from HHS to establish a statewide HIE. **The AHA supports HIEs 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 move to ICD-10 because it provides greater precision in the classification of disease. In 2012, HHS announced a one-year delay in ICD-10 implementation, until Oct. 1, 2014. The delay was prompted in part by problems implementing a new version of the *Health Insurance Portability and Accountability Act's* (HIPAA) transaction standards that interrupted payments for some hospitals and physician offices, as well as by growing evidence that small providers were behind in the implementation process. The AHA supported this short, 12-month delay and recommended that HHS keep the transition for both diagnoses and procedures (ICD-10-CM and ICD-10-PCS) on the same timeline.

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 recommends the creation of a national unique identifier system to connect records and 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.

Operating Rules. The administrative simplification provisions of the *Patient Protection and Affordable Care Act* (ACA) call for the adoption of operating rules to improve the efficiency and effectiveness for each of the HIPAA transaction standards. The operating rules are intended to reduce variation in how individual health plans and clearinghouses actually implement the HIPAA transaction standards by adopting standardized best practices. The rules also seek to establish performance expectations on the electronic response to an inquiry in order to ensure a satisfactory response time. The ultimate goal of these new operating rules is to reduce administrative burden and cost for all parties.

CMS designated the Council for Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) as the authoring body responsible for the advancement and creation of all of the operating rules. **The AHA successfully advocated that CORE's governance model be revised to include a balanced number of provider and health plan representatives to oversee the development of operating rules, as well as inclusion of other stakeholders.**

At the AHA's urging, the ACA included legislative language that requires health plans to file a statement with HHS certifying that their data and information systems are in compliance with the HIPAA standards and the corresponding operating rules starting Dec. 31, 2013. Failure to adhere to the operating rules will result in significant penalties on a health plan that is non-compliant. Key compliance dates for operating rules are as follows:

- Jan. 1, 2013 – Eligibility and claim status
- Dec. 31, 2013 – Health plans must certify their information systems are in compliance with the above operating rules
- Jan. 1, 2014 – Electronic funds transfer and electronic remittance advice
- July 1, 2014 – Adoption of other transaction operating rules
- Jan. 1, 2016 – Effective date for using operating rules for other transaction standards (such as claims or enrollment)

The AHA will continue to actively participate in the development of operating rules in collaboration with state and other national hospital associations. We encourage hospitals to join CORE to ensure that the hospital perspective is fully voiced.