Health Information Technology

Background

Research has shown that certain kinds of health information technology (IT) – such as computerized physician order entry (CPOE), electronic health records (EHRs) and bar coding – can improve care delivery and increase efficiency. To provide needed funding for adoption of EHRs, the *American Recovery and Reinvestment Act* (ARRA) authorized the Medicare and Medicaid EHR Incentive Programs, which began this fiscal year. Except for the first year of the Medicaid incentive program, these funds are available only to hospitals that can demonstrate they are "meaningful users" of EHRs.

Last year, the AHA successfully advocated for a more reasonable and flexible set of meaningful use requirements in Stage 1 of the program. 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 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 to qualify for incentive payments.

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, a January 2011 AHA survey of almost 2,300 hospitals found that fewer than 2 percent of respondents could meet all of the current certification and meaningful use requirements at that time.

The regulations are complicated and could, if not fixed, limit the success of the program. The AHA is targeting several aspects of the incentive programs for improvement.

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 is working with CMS to clarify requirements and ensure that the systems to register for the meaningful use incentives and attest to meeting the requirements are useable.** This includes ensuring that hospitals can, with permission, help their physicians sign up for the program and attest to meeting the requirements.

ONC has promulgated complex, confusing and costly certification rules that, if not simplified, will prevent health care providers from receiving EHR incentive payments, increase the costs of EHR installations and limit innovation in the health IT market. If ONC cannot make its rules work, then Congress should direct CMS to treat hospitals and physicians that can meet all of the functional and quality reporting requirements of meaningful use – without any weakening of those requirements – as if they have certified systems. The AHA urges Congress and the Department of Health and Human Services (HHS) to adopt such a "grandfathering" provision for certification.

Meaningful Use Stage 2. Looking forward, the timelines for the incentive programs are unrealistic, with CMS planning to raise the bar on meaningful use beginning October 1, 2012. This timeline is too aggressive for a new program, and is especially challenging 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 other health reform initiatives that will require calculation of quality metrics and other information system changes.

Stage 2 of meaningful use should not start until at least 75 percent of hospitals and physicians have successfully achieved Stage 1, and no sooner than October 1, 2013. **The AHA will work to ensure that Stage 2 is feasible and focuses on uses of an EHR that are known to improve care. We will closely monitor the impact of the program on small and rural providers, to ensure that it works to close, not widen, the existing digital divide.**

Multi-Campus Hospitals. In the final rule on meaningful use, 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 for the entire system rather than a separate payment for each hospital. However, each site will still incur considerable costs in implementing an EHR. 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 strongly advocates that Congress pass legislation allowing 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, psychiatric facilities 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. **The AHA believes that 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's paper "Physician Partners" for more details.

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. The health reform law also included funds to support development of the infrastructure to support health information exchange (HIE). In the past year, each state received funds from 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. While the deadline for implementation is not until October 1, 2013, the AHA has launched extensive educational programs to help hospitals prepare for this significant and complex transition. Many provider and health plan databases and applications will be affected; therefore, it is important that transition efforts be under way since it will require careful planning and coordination of resources to meet the deadline.

To accommodate the adoption of ICD-10, a new version of the *Health Insurance Portability and Accountability Act* (HIPAA) transaction standards is slated for implementation beginning January 2012. These new standards will give hospitals better patient eligibility information, such as deductibles and copayment amounts. The AHA also is working with hospitals and CMS to coordinate new requirements to facilitate the adoption of the claims attachment transaction. This transaction is expected to lessen the burden on hospitals to comply with insurer requests for supplemental clinical information.

Administrative Simplification. At the urging of the AHA and others, the *Patient Protection and Affordable Care Act* (ACA) significantly expands efforts to establish uniform standardized transactions and administrative processes

among health plans, clearinghouses and providers by requiring the adoption of a single set of "operating rules" for each of the HIPAA transaction standards. Operating rules are intended to reduce variations in how individual health plans and clearinghouses actually implement HIPAA transaction standards; ultimately, they bring further administrative efficiencies and cost savings by adopting standardized best practices. The ACA imposes significant penalties on health plans that do not comply with these standards and operating rules by the deadlines outlined in the law. The operating rules are being developed through a consensus-based process involving all stakeholders, including hospitals. Also, the rules are being developed in stages:

- eligibility and claims status;
- electronic funds transfers and claims payment/remittance advice;
- unique health plan identifiers; and
- claims or encounter information.

The Committee for Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Electronic transactions (CORE) is developing the first stage, and possibly subsequent stages, of operating rules. In addition to requiring the adoption of operating rules for transaction standards, the ACA requires the HHS Secretary to expand into additional areas, such as claims attachments, enrollment/disenrollment, health plan premium payments, and referral certification and authorization standards.

The AHA joined the CORE as a participating organization to ensure that the hospital perspective is fully voiced. We are working with CAQH to broaden CORE participation by providers and other stakeholders. The AHA also is collaborating with state and other hospital associations to expand the provider expertise and involvement brought to this development process. We encourage hospitals to join CORE.

Accounting for Disclosures. The AHA is concerned about the privacy provision in the ARRA that expands providers' responsibility to account for disclosures of personal health information. Under current law, hospitals must account to patients for disclosures of their personal health information, but not for disclosures made in the course of treatment, payment and health care operations (the most frequent disclosures). The ARRA expands the "accounting for disclosures" responsibility to include disclosures for treatment, payment and operations purposes, which significantly increases hospitals' reporting burden. However, the ARRA shortened the look-back period so that hospitals will be required to account for disclosures for only three years, instead of the current six-year requirement.

While the statute established deadlines for hospitals to incorporate this expanded reporting requirement within their electronic systems, the ARRA allows the HHS Secretary some flexibility to delay these effective dates. HHS has yet to release even a proposed rule related to the expanded reporting obligations; and given all of the ever-increasing requirements hospitals are trying to meet to be meaningful users, **the AHA urges the HHS Secretary to delay the expanded disclosures reporting requirements for all hospitals to 2014.**

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 expected to introduce this year 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.**