NOT WHAT THE DOCTOR ORDERED: BARRIERS TO HEALTH IT FOR SMALL MEDICAL PRACTICES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE AND TECHNOLOGY

OF THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES
HOUSE OF REPRESENTATIVES

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HEARING: NOT WHAT THE DOCTOR ORDERED: BARRIERS TO HEALTH IT FOR SMALL MEDICAL PRACTICES

THURSDAY, JUNE 2, 2011

HOUSE OF REPRESENTATIVES
COMMITTEE ON SMALL BUSINESS,
SUBCOMMITTEE ON HEALTHCARE AND TECHNOLOGY
Washington, DC.

The Subcommittee met, pursuant to call, at 10 a.m., in room 2360, Rayburn House Office Building. Hon. Renee Ellmers (chairwoman of the Subcommittee) presiding.

Present: Representatives Ellmers, Herrera Beutler, Tipton, Hanna, Richmond, Altmire.

Chairwoman ELLMERS. We will go ahead and get started. Thank you, Mr. Richmond, our ranking member. And we have today with us Congresswoman Herrera Beutler from Washington, who is on our Subcommittee.

This is the Subcommittee on Health and Technology of the House Committee on Small Business. And the title of our Subcommittee hearing is Not What the Doctor Ordered: Barriers to Health IT for Small Medical Practices.

Good morning to everyone. I call the hearing to order.

This is a very important issue for our health care providers and health care across our country.

Health information technology is the computerized management of health information. It has the potential to improve health care delivery, decrease medical errors, increase clinical and administrative efficiency, and reduce paperwork. Studies have shown that adoption of health IT is becoming more common, but the transition is a slow one. In 2010, the Centers of Disease Control and Prevention found that only 25 percent of office-based physicians had fully functional electronic health records or EHR. And 10 percent had a basic EHR system. Studies have shown that there is a digital divide on health IT between large and small medical practices. A study of eastern North Carolina confirmed the existence of the digital divide and found that the smaller medical practices is, the less likely to be using the EHR.

As a registered nurse and the wife of a surgeon who has health IT, I understand that a modern efficiency and well-equipped office is critical to the practice of medicine. Health IT offers promise to all medical professionals; however, financial, legal, and technology barriers prevent many, particularly small practices, from moving forward on EHRs. This issue is critical because almost 60 percent

of office-based physicians work in practice with fewer than 10 doctors. In fact, the small practice is said to be the best indicator of the success of EHRs because it is likely to be the last to widely adopt the technology.

Since 2009, many physicians have received Medicare incentive payments for e-prescribing part D medications. Beginning this year, doctors are eligible for Medicare and Medicaid incentives under a separate program if they demonstrate meaningful use of electronic health records. I am particularly concerned that physicians may not be aware that they must report e-prescribing activity this year to avoid e-prescribing penalties that will begin next year. There are other challenges, too. As more personal information is available electronically, patients must feel confident that their medical information is secure and their privacy is protected. And physicians need to be assured that the information that they transfer is not changed or misused.

We look forward to hearing from today's witnesses about how these barriers can be addressed. I now yield to our Ranking Member Richmond for his opening statement. [The information follows:]

Mr. RICHMOND. Thank you, Madam Chairwoman. And I want to thank our panelists and our guests that are here today to discuss this very important issue, specially as we try across this country very diligently to improve our health outcomes and to make sure that we provide the best medical care that we can do—that we can possibly do. And that means effectively using our information technology to do that.

So today's hearing will offer an opportunity to examine ways that we can improve the implementation of health information technology. Health IT has the potential to advance health care quality while reducing costs, but right now many small health care providers simply cannot afford it. We have seen the benefits recent technology can bring to our daily lives in a variety of ways. It is now time for our health care system to catch up with the benefits of health IT that are numerous and wide-reaching for all sizes of medical practices.

Those fortunate enough to have access to this technology already know how it decreases health care costs, improves patient safety, and reduces the practice of defensive medicine. These system-wide benefits ultimately to an increased access to affordable health care.

Since Hurricanes Katrina and Rita, when physicians struggle to provide adequate care because they lacked access to patients' health IT, it has been a key concern for my state, which is Louisiana, and our health care industry. I am proud to say Louisiana has been focused on creating a health information exchange since 2007 and was among the first states to offer incentive patients to Medicaid providers this year. We have made upgrading our health IT infrastructure a priority and I am honored to have Dr. Elliott, a solo practitioner from my district here today to share her experiences.

From a business perspective, fully functional electronic health records have the potential to improve a practice's net profit by over $80,000 during a five-year period. In addition, effective health IT can increase the doctor's time with the patients and improve administrative efficiency by reducing paperwork. Such benefits make

a clear case as to why health IT is needed to assist small practitioners who strive to provide the best care to their patients. However, right now there are inadequate incentives for health care providers to adopt many of these technologies. With 80 percent of the nation's patient care delivered by small practices, it is important to understand why most of them do not use health IT. Small practices face a number of unique challenges, including financial barriers and complex regulations. Besides upfront costs exceeding $40,000 to implement the technology, small practices face additional design costs, practice disruption, and a lack of certified products. As a result, a significant gap exists in health IT adoption between large and small practices.

I will just—I will insert the whole statement for the record but I just want to say and comment our Chairwoman Ellmers and add to the audience that I think that this is where Congress works best, when we acknowledge that we know what we know and we know what we do not know. And those things that we do not know we look to the people who do it on a daily basis and the people who have the on-the-ground expertise. So we look forward to hearing the testimony today because it will be your testimony, your suggestions, and your input that guides the way that we work towards solving this issue in a bipartisan way because the issue is too important not to get it done. It saves lives, reduces costs, and all of those things that I know we are all committed to doing on both sides of the aisle across every walk of life.

So thank you to the Chairwoman and thank you to the panelists. [The information follows:]

Chairwoman ELLMERS. Thank you, Mr. Richmond for your comments. And I cannot agree more on what you stated.

I now would like to ask Ms. Herrera Beutler for her opening comments.

Ms. HERRERA BEUTLER. I will keep it brief. I want to share a story. I had a young nurse, a young woman in my district in Clark County come and visit with me a month or two ago. And she was there to talk about electronic medical records, personal health records, or e-records for hospitals or small practices or solo practices. And her story was compelling.

Her father, who was a constituent of mine, would bike every day up and down a certain—perfect physical health. He was between 55 and 60, I believe. Tremendous. And he had had—I do not know if it was a palpitation. He had a problem. They took him to the ER. And she was a nurse. She went with her mom and she said we think there is something here. She said I think there is a specific issue here. And they ran the tests and they waited and the tests came back negative. They said you are fine. So they sent him home. And I think within—I think it was two weeks. It was a shorter period of time. He had it happen again and he died. And, you know, she was devastated. The family was devastated. And she said about—a short period of time after that she received a call from the hospital that said we are so sorry. We lost the paper record. And it actually was not negative. And went on to explain it was a problem with the paper. It was a problem with losing the paper.

And it is so hard to sit there and have someone—you hear about it. You hear this is partially why we need to upgrade and we need to get there. And here is someone who works in the medical profession and she was looking at me saying do everything you can to speed the implementation of electronic medical records for many reasons.

We talked about Katrina. I have Lewis County in my district. We have—Kent has severe flooding, which wipes out homes. Floods eight feet plus of the bottom and up to second story homes. And when that happens, these are older communities, their medical records could be—I do not know. Their immunizations could be stuffed somewhere in a file. And what happens? We lose patient records. And it is imperative.

I served here on the Hill as a health policy aid before elected office, before going home and then coming back here. And this was a bubbling issue, you know, in the last decade. This has been something Washington State has worked towards, a state partnership along with the federal efforts in a very bipartisan way because we recognize we have to get there.

The challenges are costs and implementation. I have a doctor from southwest Washington who is going to share a little bit about her experience, but the reality is we are trying to find out what we do not know, to Mr. Richmond's point, and figure out how we can speed this along. Because paper is—as someone who represents a timber industry, I like using paper in a lot of areas. Let me put that on the board. But when it comes to this issue we need to make sure that we are entering the 21st century.

So with that I yield back. I look forward to our testimony.

Chairwoman ELLMERS. Thank you. And I will just start off by a little housekeeping. As far as the light system, you will have five minutes to deliver your testimony. I will be lenient if you go over because I value so much your input. And the light will start out as green. When you have one minute remaining the light will turn yellow. Finally, it will turn red. And then that basically ends your five-minute period of time. And I ask you to try to stay to that, but again, we will be lenient today for the purposes of this Subcommittee.

STATEMENTS OF FARZAD MOSTASHARI, M.D., NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; KAREN TRUDEL, ACTING DIRECTOR, OFFICE OF E-HEALTH STANDARDS AND SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES; SASHA KRAMER, M.D.; DENISE ELLIOTT, M.D.; ANDREW SLAVITT, CEO, OPTUMINSIGHT; DAVID L. BAUMER, PH.D., PROFESSOR OF LAW AND TECHNOLOGY, NORTH CAROLINA STATE UNIVERSITY

Chairwoman ELLMERS. With that, I would like to introduce our first panelist, Dr. Farzad Mostashari. He is the national coordinator of health information technology with the U.S. Department of Health and Human Services. Dr. Mostashari became the national coordinator in July 2009. Previously, he served in the New York Department of Health and as Assistant Commissioner for the Primary Care Information Project, where he facilitated the adop-

tion of health information technology by providers in underserved communities. Dr. Mostashari did his graduate training at the Harvard School of Public Health and Yale Medical School, and his internal medicine residency at Massachusetts General Hospital.

Thank you so much for being here today, and again, you have five minutes.

STATEMENT OF FARZAD MOSTASHARI

Mr. MOSTASHARI. Good morning, Chairwoman Ellmers, Ranking Member Richmond, distinguished members of the Subcommittee. I am Dr. Farzad Mostashari, the national coordinator for health information technology at the Department of Health and Human Services. Thank you for giving me the opportunity to appear before you today to talk about what the Office of the National Coordinator is doing to support the deployment and meaningful use of electronic health records, especially among smaller physician practices.

I know from personal experience, both the importance and the challenges of using better information to improve individual and population health, especially in a small practice setting. As the former head of the Primary Care Information Project in New York City, we reached out to practices that served Medicaid patients and signed agreements with providers in small practices and community health centers and hospital outpatient departments to establish electronic health records systems.

Over half of small practices in the city's three most underserved communities eventually signed up with the program. In a little over a year, more than 1,000 providers started live-use of EHR systems with a 99 percent implementation success rate. It was hard.

The Office of the National Coordinator's Core mission is to improve patient care, improve health outcomes, and make the health care system more efficient through the effective use of health IT. Much of ONC's work is aligned in support of a Medicare and Medicaid meaningful use EHR incentive programs. These programs, which my colleague from CMS will talk about in more detail, provide financial incentives to eligible providers and hospitals that adopt and use electronic health records in a meaningful way to improve health and health care outcomes. This unprecedented public investment does not treat technology as an end to itself. Rather, it will result in concrete progress towards our policy objectives—measurable improvements in health and reduction in costs.

I would be happy to talk about all the ways that ONC is supporting this transformation in health care, but in the interest of time today I will highlight some of our major initiatives.

ONC is at the center of efforts to establish standards for EHR systems and let providers and the public know which EHR systems are meeting these standards. We currently have six authorized private sector certification bodies which have certified more than 700 separate EHR products. This is indicative of the development of innovative EHR products that are less expensive and easier to implement for small practices than ever before. Of note, 60 percent of the vendors of these systems are small businesses with fewer than 50 employees.

Our Regional Extension Center program, inspired by the Agricultural Extension Center program, supports a network of 62 state

and local organizations that offer training, information, project management, and technical assistance to providers in order to ease and accelerate the adoption and meaningful use of EHR technology. Particularly by primary care providers, small practices, critical access hospitals and other underserved or underresourced providers. The Regional Extension Center program has enrolled more than 70,000 providers, 94 percent of whom are primary care providers and about half are in individual or consortia of small practices.

ONC's Health Information Exchange program is helping build the infrastructure for sending and receiving electronic health information securely across the nation's health care system with a focus of simple but secure technologies that can be used by all providers to improve coordination of care, whether they care for patients in small practices, urban clinics, or rural hospitals.

These efforts have sparked a remarkable growth in the health IT industry as a whole, which has led to a strong demand for skilled works. To address this emerging shortage, ONC has supported 82 community colleges in establishing health IT certificate programs where training can be completed in six months or less. So far, over 2,400 students have graduated from the community college programs. Another 4,700 are currently enrolled, and we are on our way towards our target of graduating 10,000 students every year. Many of these graduates will end up helping small practices who often lack the resources for dedicated IT staff to successfully implement EHR systems.

Finally, I want to point out that ONC, along with our partners at CMS, the Office of Civil Rights, and other federal agencies have taken a number of important steps towards making sure electronic health records remain private and secure. ONC has embedded privacy and security into all of our programs and policies. For example, the standards and certification criteria I spoke about require that EHRs have the capability of encrypting electronic health information, tracking who accesses each record, and limiting user access. Meaningful use requires that providers conduct a security risk assessment and mitigate any risks identified. Our Regional Extension Centers are providing technical assistance on protecting privacy and security and our new health IT training programs ensure that the future generation of technical workers are well grounded in privacy and security.

Health information technology is indeed a critical foundation that supports efforts to modernize and transform our health care system. Now is the time to get down to the hard work of implementing and using health IT in a way that leads to better health care that is high quality, safe, coordinated, efficient, effective, and patient-centered. And I am proud of ONC's role in achieving that goal.

Thank you for giving me the opportunity to appear before you today. I look forward to answering any questions you might have.

[The statement of Mr. Mostashari follows:]

Chairwoman ELLMERS. Thank you, Dr. Mostashari.

I would now like to introduce our second panelist today, Karen Trudel. Ms. Trudel is acting director of the Office of E-Health Standards and Services for the Centers of Medicare and Medicaid Services in Baltimore, Maryland. The Office of E-Health Standards

and Services coordinates implementation of the comprehensive e-health strategy for CMS. Ms. Trudel also has responsibility for enforcement of Health Insurance Portability and Accountability Act standards and oversees the areas of personal health records and electronic prescribing.

Welcome to you. And you have five minutes for your testimony.

STATEMENT OF KAREN TRUDEL

Ms. TRUDEL. Thank you, Chairwoman Ellmers, Ranking Member Richmond, and members of the Subcommittee. Thank you for the invitation to discuss CMS's implementation of the Electronic Health Record (EHR) Incentives program created by the Recovery Act and specifically the impact of this implementation on small and solo providers.

The widespread adoption of certified EHR technology used in a meaningful way is one piece of a broader health information technology infrastructure needed to modernize our nation's health care system. As we have worked to implement the EHR incentive program, we have sought to strike a balance between setting program requirements high enough to move providers expeditiously towards this goal but not so high that providers choose not to participate in this voluntary initiative.

The Medicare and Medicaid incentive programs provide incentive payments for eligible professionals and hospitals that demonstrate meaningful use of EHR technology. The Medicaid incentive program also provides incentive payments to providers in their first year of participation if they adopt, implement, and upgrade EHR technology. Eligible professionals can receive up to $44,000 over five years from the Medicare program, or up to $63,750 or six years through the Medicaid program. The hospital incentive payments for Medicare and Medicaid are calculated with a formula that begins with a base amount of $2 million with an added amount based on the number of discharges.

Providers must register to participate in the programs and attest that they have either adopted, implemented or upgraded certified EHR technology or that they have meaningfully used that technology during a 90-day reporting period. We recognize that for some providers, particularly small and solo practices, moving to adoption and meaningful use of EHRs is a huge shift from current practice. For that reason, CMS has taken an escalator approach to meaningful use envisioning three separate stages that demand increasingly vigorous requirements.

We are currently in the first stage, which focuses on using EHRs to collect clinical data, electronic prescribing, initial steps toward patient engagement, and, as Dr. Mostashari mentioned, ensuring privacy and security of patient information. We originally proposed 25 meaningful use criteria for eligible professionals and 24 for hospitals. The provider community commented that meeting all those criteria would be difficult and they requested flexibility. We responded by separating the criteria into a core set that all providers must meet. And those are 15 for eligible professionals and 14 for hospitals. And a menu set with providers being able to select five of the remaining 10 criteria to implement.

Less than a year after publishing the final rule, CMS is already providing incentive payments to providers. Since January 1, 2011, more than 42,600 eligible professionals and hospitals have registered for either the Medicare or the Medicaid EHR incentive program via a web-based application. The same application is used for Medicare providers to attest to their meaningful use of the EHRs. States are developing their own out-of-station mechanisms and data is exchanged bi-directionally with CMS and the States. Providers were first able to begin to attest to meaningful use beginning April 18th of this year, and 485 providers did so successfully in the first month of the program. The first Medicare payments totaling $75.9 million went out to meaningful users on May 19th.

CMS is encouraged that States across the country have already shown strong enthusiasm for the EHR incentive program. States began launching their programs in January. Fifteen states have launched to date and two more are set to come online next week. Further, the majority of states have indicated to us they will launch by the end of calendar year 2011. And as of May 4th, over $83 million in Medicaid incentive payments have been made.

CMS strives to increase awareness and participation in the incentive programs by offering a variety of information and tools that providers can use to learn about and successfully participate in the programs. We use a variety of mechanisms to engage providers, including social media, national provider calls, and webinars. We have developed a special website containing guides that explain the meaningful use requirements, user guides for the web-based system, and many other products. Our strategy focuses on making free, high quality information available through mechanisms that are accessible to busy providers.

The administration has made the adoption of meaningful use of EHR technology a high priority. Our stage one rule lays the groundwork for establishing a robust national health infrastructure that supports the adoption of EHRs and PHRs and will help providers practice safer and more productive medicine. We look forward to working with Congress, our many stakeholder partners, and our colleagues at ONC to ensure that the implementation of the EHR incentive program fosters an expanded use of health information technology, broadens the information exchange infrastructure, and promotes the adoption of electronic health records as intended by Congress.

I am happy to answer any questions you might have. Thank you.

[The statement of Ms. Trudel follows:]

Chairwoman ELLMERS. Thank you so much. I am going to ask a few questions and then I will yield to Mr. Richmond, our ranking member. And we will go from there.

My first question is for you, Ms. Trudel. The meaningful use, you touched on it in your opening statement. Can you once again reiterate what it is and how it is that physicians and hospitals are adhering to it? Because that is obviously the proof that they have to provide.

Ms. TRUDEL. Right. Exactly. I will walk through some of the core requirements for meaningful use, and I think that will give you a good idea of where we are trying to go with that. A number of the core requirements focus around capturing data in the electronic

health record so that it can be used over and over for clinical reasons. Some of those include capturing a list of current and active problems, medication lists, vital signs, allergies, smoking status, demographics. So those are the things that we are capturing in the EHR. Then there are some things that are action-oriented, like computerized provider order entry and electronic prescribing. And of course, the privacy and security requirements.

Chairwoman ELLMERS. What would happen if a physician did not actually—what would happen if they were not able to provide that information to you?

Ms. TRUDEL. For this first year, and again this is a voluntary program, the provider can register for the program and then has the entire year through to February of 2012, to report that they have meaningfully used for a 90-day period of their choosing. So they can decide what that period is. They track these requirements, make sure that they have met them, and at that point they would sign on and say I am a meaningful user. If they do not do that in the first year, they can choose to wait until the next year to start out and it does not have any effect on the total payment that they could receive.

Chairwoman ELLMERS. So there are no penalties assessed for the first year?

Ms. TRUDEL. Absolutely. The penalties do not take effect until 2015.

Chairwoman ELLMERS. 2015. And that would not reflect retroactively at all?

Ms. TRUDEL. No.

Chairwoman ELLMERS. Okay. I do want to clarify one thing and I hope you can do this for me. You mentioned the incentives in Medicare and Medicaid but you cannot get incentives for both. You basically have to—correct me if I am wrong, but the physician would have to choose which one he would—he or she would like.

Ms. TRUDEL. Right. The eligible professionals must select one or the other. Hospitals, on the other hand, including critical access hospitals, can participate in both programs.

Chairwoman ELLMERS. Okay. So hospitals can participate in both but physicians cannot. Thank you.

Dr. Mostashari, I have a question about funding that was provided with the American Recovery and Reinvestment Act for HIT. Our records show that $2 billion was provided for this. How has that been utilized? And has all of it been utilized? Or is there other monies out there? How are we going to apply that?

Mr. MOSTASHARI. Thank you. Yes. ARRA provided for $2 billion for the national coordinator to help establish the infrastructure that would permit providers to achieve meaningful use of electronic health records as well as increasing the privacy and security of such systems. We have obligated $1.97 billion of the $2 billion. The largest single chunk goes towards the Regional Extension Center program. Some $720 million to establish those assistance—technical assistance and project management facilities for small practices and critical access hospitals and so forth. There is approximately $560 or so million that went to state and state-designated entities for information exchange purposes. We have $265 million that went to beacon communities. These are 17 communities, kind

of our crown jewels. And I promise the fact that on this panel—have beacon communities in your states is completely accidental. And these are really the crown jewels that are showing how information technology can work.

Chairwoman ELLMERS. Oh, so when you say beacon, is that, your field test?

Mr. MOSTASHARI. These are communities that were ahead of the curve, whether it is in Piedmont, North Carolina; whether it is Crescent City; the inland Northwest beacon community or Grand Junction, Colorado which are putting it all together. They have higher rates of electronic health record adoption than other parts of the country. They also have governance mechanisms and leadership to use those—the technologies, the redesign of physician practices, the performance monitoring and feedback, and really bringing all the tools to bear to show how health information technology and its meaningful use can show demonstrable and near-term impact on cost and quality of health care.

Chairwoman ELLMERS. Thank you so much. I yield now to Mr. Richmond, our ranking member.

Mr. RICHMOND. Thank you. I will direct this question actually to both witnesses. And I can only think back to my life, and especially my childhood when we talk about motivating me to do one or two things. It was either the carrot or the stick. And in thinking of that I guess my question would be for many physicians. Medicare and Medicaid reimbursements are already low. The penalties that could further diminish these payment rates for practices that do not transition to electronic health records. And what I am afraid of is, especially in Louisiana, where we see more physicians denying to see Medicaid and Medicare patients. And as HHS and CMS examine how these penalties may ultimately affect access to health care.

Ms. TRUDEL. I would start by pointing out that there are no penalties in the Medicaid program at all. The payment adjustments are related to the Medicare program solely. However, you make a good point and I think that the balance in the legislation was that there was a carrot and stick approach but I would venture to say that when you add the incentive programs together with what ONC has done to help to assist providers, especially small and solo providers, to move toward electronic health records, the carrot is a lot larger than the stick.

Mr. MOSTASHARI. And I would add that our goal is to have as few providers, eligible professionals and hospitals that would incur the payment adjustments as possible. We want to help everybody succeed in this program. We really want and are doing everything we can to make it so that we not only have an ambitious program but one that is achievable and that we provide the supports and whatever else is needed to help every provider succeed on this track. And I think you do need both the incentives and the penalties to get to this transformation, but you also need the supports around it to help people succeed.

Chairwoman ELLMERS. Mr. Richmond, will you yield? I have a question about the penalties versus the incentives. Is there a time limit on the incentives? I know the penalties start in 2015 but do the incentives continue on or does that stop at 2015?

Ms. TRUDEL. For Medicare purposes, the incentives extend for a five-year period. And they start with a maximum of $18,000 per year per provider and are scaled down to $2,000 per year per provider. For Medicaid, the incentive period goes on for six years and it is frontloaded with a first year incentive of $21,250.

Chairwoman ELLMERS. And the penalties? Starting in 2015, does that extend on?

Ms. TRUDEL. Right. No penalties for the Medicaid side, as I said. And for Medicare, they phase in, again, with a one percent penalty in 2015, moving to a two percent in 2016, and then between three and five extending indefinitely after that.

Chairwoman ELLMERS. So there are penalties indefinitely?

Ms. TRUDEL. Exactly.

Chairwoman ELLMERS. Okay, thank you. And I thank Mr. Richmond.

Mr. RICHMOND. And this question would be for Dr. Mostashari. The question is based on the idea, and I want to commend you all for a very open and competitive certification process and market.

The concern is whether the deal in accreditation has burdened small providers. And if it is true, especially for those in need of practice compatible EHRs, did you all consider the potential impact of the delays when developing the certification program?

Mr. MOSTASHARI. It was quite a concern. A little bit of background on this. Prior to the passage of HITECH there was only a single accreditation body. There was the Certification Commission for Health Information Technology. And the legislation—the HITECH legislation asked us to take another look at that. And the reason was because there were some who were concerned about having only a single point and not having options or choice and a competitive marketplace around that process.

So we were required to take a look at that, and our federal advisory committees recommended to us that we, in fact, change that. And we opened it up and have more competition in the accreditation process. There was a risk, however, that you point out in this switchover that there would be a time where we would not have sufficient products certified or the pipeline for getting a product certified could hinder the ability of providers to meet meaningful use. And so we created a temporary program that could go into place quickly and a permanent program. The temporary program, indeed, went into effect very quickly and I think we have not heard much in the way of concerns about the certification program. And that is a good thing because it is working. We have now six accredited testing and certification bodies instead of where we had one. The cost of certification has come down. The speed of certification has gone up. We hear from vendors that the quality of service they are receiving has increased, and we now have more certified products than ever before. So in this case, it was a concern but I think with the right policies and with the right implementation we have managed to address that well.

Mr. RICHMOND. Good. And then my last question directed at both of you or both of you feel free to answer or not answer. But the last question is just in today's age with so many concerns with security and privacy—I also sit on Homeland Security so I am very aware of the fact that everyday there are thousands of people that

wake up trying to hack into either the .gov world or the .com world. And we have to be concerned about that.

And what I am asking about now are complaints that especially for small practitioners that there is little guidance on how to safeguard to ensure HIPAA compliance. And what can we do, what can you all do to help those small practitioners overcome that fear? And after that I will yield back, Chairman.

Mr. MOSTASHARI. Absolutely. And maybe after my colleague from CMS can speak about that.

Safeguarding privacy and security is a shared responsibility. And the practices, not just in terms of their professional responsibilities, not only in terms of patient expectations, but also under the law have a responsibility to safeguard the patient information that has been entrusted to them. And the Office of Civil Rights has the ability to investigate any complaints and can levy substantial fines as they have done against some hospitals and health plans recently.

But we need to, as you say, support providers, particularly the smaller practices in being able to do this. We are working with the extension center program to provide that technical assistance, to provide that checklist, that easy to understand, easy to use checklist. Some templates and best practices are on how to do the appropriate way, whether it is physical security, administrative security, clinical security settings, configurations and so forth in the small practice setting. And that information is available not only to providers who work with the extension centers, but to any provider.

We are also working to make it easier on the technology side through our research and development programs. We have a consortium of academic medical centers who are at researchers' institutions who are working to develop the next generation of technologies to make it the easy thing to do, the secure thing to do. And to make it almost a default and to bake into the products the ability to encrypt automatically, for example, and to safeguard patient privacy.

But as you point out, it is a—we can just remain ever vigilant. This is a daily war where the folks of the other side are constantly looking for new opportunities, new vulnerabilities, and new technologies. And we have to, on our side, be ever vigilant as well.

Chairwoman ELLMERS. Well, thank you, Mr. Richmond. And I now yield to Ms. Herrera Beutler, for her questions.

Ms. HERRERA BEUTLER. I will make it brief. Thank you, Madam Chair.

A couple of things you mentioned, Ms. Trudel, that kind of sparked my interest, with regard to penalties, did I understand you right when you were saying that for hospitals versus, you know, group practices there were different—I know they went into effect on different implementation dates and I know Medicaid is withheld from the penalty side. Did I hear you say that hospitals are exempt? At the very beginning, what did——

Ms. TRUDEL. No, hospitals and eligible professionals are both subject to the same penalty at the same time.

Ms. HERRERA BEUTLER. Okay. Okay. And in terms of small group or solo practitioners, I mean, a hospital system is going to have a lot more wherewithal to implement any HER, period—a small group practitioner or a solo provider in a rural area, who is not a

critical access hospital. Right? I know we have brought that up—is going to have a hard time making this investment, particularly if they are the only family physician or OB in a region. And I have met some of those doctors. Are you taking extra precaution and care and assistance? Because I heard you talk about a lot of—the goal is to assist—with some of those in recognizing—especially if we are talking about a family doc—it is an aging population. Right? Not very many people are going back into this practice and that is a whole other issue. But some of them I have met have said do you know what? I can run my practice. I have figured this out. I have enough problems with med-mal and everything else. Do not bring this my way. How are you overcoming that in a non, you know, penalty way?

Ms. TRUDEL. First, I would like to talk a little bit about the outreach that we have been doing which is very much geared toward reaching exactly those kinds of providers.

As an example, our 10 regional offices over the past nine months have conducted over 400 events, more than half of which were targeted specifically to, or included, significant quantities of small and rural physicians to try to explain to them what the program is, what the advantages are of it, how to take advantage of it, and what some of the other tools and resources, including the Regional Extension Centers, are available to them so at least they have the ability to fully and completely assess the opportunity and make a decision as to whether or not they want to take advantage of it.

Ms. HERRERA BEUTLER. What kind of feedback, and this is a question I will ask of the next panel as well because they are the docs doing this, what kind of feedback have you had from them? What kind of uptake—positive or negative?

Ms. TRUDEL. We are actually getting good uptake. We have been doing some trending over the period of the last year and we are getting a sense that many, a large percentage, I would say over 70 percent of the physician practices that we are talking to, actually have exhibited some interest and are thinking about it.

Ms. HERRERA BEUTLER. So when they have problems, right, with a company that was certified by one of the six, you know, certification agencies, what is their recourse?

Mr. MOSTASHARI. Let me talk about the supports that we are offering. Dr. Brull was one of the first providers to get their payments for meaningful use last week, and she spoke about working with the Regional Extension Center in Kansas where she is a family practitioner in a small practice. And she talked about how when she first saw the—started adopting the systems and saw the list of requirements, that she was daunted by that. But that the Extension Center helped give her an understanding of what is really behind the meaningful use, practical steps on how to achieve it, help with project management. And she gave one example about saying there were quality measures around colonoscopies. And she thought she was doing a pretty good job with colonoscopies that can be lifesaving if they identify cancers early on and they can be removed. And she said when she actually had the information to look within her data she was only doing it about 40 percent of the time. And she was really upset. But then the technology helped her make a list of all the patients, reach out to them, have reminders

in the system. Those are all part of meaningful use. And she reported that she was not satisfied yet but things were better; she was at 84 percent now. And she said I would never go back to being on paper.

So I think what we have in our favor is that providers, even though the road is hard, providers like Chairwoman Ellmers husband, who has gone through the hard work, would never go back to using paper-based systems. And it is rewarding because it is in line with what they want to do as physicians and nurses.

Ms. HERRERA BEUTLER. And really quickly, if they have not just a bump in filling out the paperwork or jumping through the hoop or meeting the quality measure, if they have a real substantive problem——

Mr. MOSTASHARI. Yes.

Ms. HERRERA BEUTLER [continuing]. Or IT provider, I mean, do they have recourse?

Mr. MOSTASHARI. Yes. The Regional Extension Centers—let me give the example. Georgia and Massachusetts Regional Extension Centers are working with banks to help their providers get loans for the hardware and software. Very practical, addressing a real need that they have. The Extension Center in L.A. are doing project management, helping them do every phrase of project management of going from implementation to meaningful use and are working directly with the vendors to identify problems and mitigate them when they have it. Ohio REC has developed a comprehensive needs assessment that goes through and helps the practices identify what are some of the weak points and gaps and barriers and working with the provideri to address any issues before they go live, rather than trying to fix things afterwards.

So those are all examples of practical ways that the extension centers all across America are working with the 70,000 providers to help them address any problems they might have and move forward productively.

Chairwoman ELLMERS. Thank you. And I now yield to Mr. Altmire for his questions.

Mr. ALTMIRE. Dr. Mostashari, I represent an area in western Pennsylvania that has some rural areas, it has some very highly developed health care systems, as well as smaller providers like you are talking about today. But what I hear all the time is that the certification process is still very cumbersome, the additional certifying entities that were there. And for folks who have failed certification, if a provider fails certification, does HHS encourage the certifying bodies to share why the certification failed, to recommend improvements that could be made the next time?

Mr. MOSTASHARI. the certification process, the way it works is that a vendor of a system, a company that manufacturers the software, would go to the accredited testing and certifying body and they would seek certification of their product. So that process we have heard relatively few complaints about. There is, as I mentioned, more competition in that area that has reduced the costs. It has increased the timeliness and the level of service that the vendors are achieving. And as a result, we now have more products certified by a whole range of vendors than ever before. So providers have—now, the health care providers who purchased these sys-

tems, they do not themselves need to go to get certified for the product. They can purchase the system that has already been certified.

There are, particularly for the larger health systems who have self-developed their own systems, we have created an opportunity for them in the regulation to get self-certified, to say I do not want to buy a product that is commercial, off-the-shelf; I want to be self-certified. And for that purpose we do have a program that would allow them to be self-certified. We have not heard much in the way of—I mean, the standards that they have to meet are the same as the standards that a vendor would have to meet and it is a rigorous process. They have to show that the products have the same security as a commercially-developed product, the same level of interoperability as a commercially-developed product, and that can be a challenge. But many of the organizations who have developed their own products are very capable and we have not heard too much in the way of concerns about that.

Mr. ALTMIRE. And that is where I was going to go actually. How do you distinguish—how does HHS distinguish between a large, very advanced on the health IT side, provider that has already spent in some cases hundreds of millions of dollars to upgrade their IT to become compliant, to go through the certification process, and then contrast that with the money that is available, the incentives, the meaningful use regulations, to a much smaller provider, maybe out in a rural area that does not have anywhere near the resources, but we all want to go in the same direction. You do not want to end up with a VA DOD circumstance where they are incompatible, they cannot communicate with each other, you want to all make sure, especially in a region but eventually for the country, we have an interoperable IT system. So how do you navigate those two very different situations?

Mr. MOSTASHARI. That is exactly right. And I think that is why the certification is so important because it says that no matter what system you are using, whether it is self-developed, whether it is the biggest vendor in the country or the small vendor in the country, they all have to meet certain requirements around interoperability. But they all have to have the codes that map to a same set of codes that if I get a piece of information from one vendor to another vendor, it can be understood across the systems, that they can produce the same sort of messages when they are reporting to public health, for example. On the quality measures, producing those. So the certification process really is our most important tool in ensuring the interoperability between vendor systems, large or small.

Mr. ALTMIRE. so you do have an end in mind. You are not just allowing everyone in sort of a free-for-all manner to come up with their own systems and get certified, but you are saying we are not going to tell you how to do it. We are not going to tell you what direction to go and what is best for you, but in the end we want to have a system where everyday can communicate with each other.

Mr. MOSTASHARI. That is exactly right. We have to balance between allowing innovation to flourish, not overspecifying to say that, you know, the box has to be this big and this wide and this

is how it has to look. Allowing innovation to flourish but saying there are some bottom-line outcomes that we are going to hold you to. Can you produce a message, an electronic message for interoperability that is specified exactly thus? Can you meet these functional requirements and ensure that we do have, not just a collection of systems that are deployed but actually systems that can work together to create the bigger public benefit.

Mr. ALTMIRE. Thank you, Madam Chair.

Chairwoman ELLMERS. Thank you. I now yield to Mr. Tipton for his questions.

Mr. TIPTON. Thank you, Chairwoman Ellmers and Ranking Member Richmond, for convening this. Obviously, a very important issue for all of our areas. And Dr. Mostashari, I appreciate you bringing up Grand Junction on the western slope of Colorado, and we are seeing that extension actually in terms of the quality health care network going down through Montrose with the idea of extending it throughout the entire western slope of Colorado.

I do have a couple of questions here in terms of just having an idea of really where we are at right now. What is the timeframe that it takes—weeks, months—to be able to get to the certification? For either of you. For doctor. Do you have any kind of averages?

Mr. MOSTASHARI. So for a provider to adopt an electronic health record system, it depends upon—very much on the product they select and the assistance they have around project management. So there are some vendors who very effectively can get a provider from start to finish in a matter of weeks. There are others, particularly for larger, much longer lead time planning, implementation, and so forth, design and custom configuration that is needed to take place. Every provider makes a decision for themselves in terms of what is in their best interest. And our hope with the extension centers is to give them the best advice we can or the extension centers can about what it right for that provider, that group, that hospital, in terms of the system that they implement.

It is a challenging process. I want to make no bones about the transformation of workflows and processes and the difficulties that many practices, particularly smaller practices, will face as they make this difficult transition. But it is a rewarding process and ultimately will be not only leading to improved patient care and coordinated care but actually will help those practices succeed financially over the long run.

Mr. TIPTON. And if I missed this I apologize. But how many people—how many practices, if you have got an average, have signed up? And out of those, how many are solo practitioners?

Ms. TRUDEL. I do not have any information about how many are solo practitioners. So far, since January we have had 42,600 health care providers register for either the Medicare or the Medicaid program. Almost all of those were physicians. And, at this point, we have had our first payment run. Let me just kind of tack onto the back of the how long it takes question. Once a provider has gotten to the point where they believe they can meet the meaningful use requirements, they then have a 90-day reporting period during which they must meet all of those requirements. As soon as they have done that, they can go online to a web system and attest to

that meaningful use and in a month or so they will have their incentive payment.

Mr. TIPTON. This may be a question maybe for the next panel. But if you would like to maybe contribute into one of the big complaints that I hear consistently from a lot of our physicians gets down to the coding issue which Dr. Mostashari, you were talking about just a moment ago. When we are talking about, like, Medicaid, is there kind of a streamlining process between requirements at the state and federal level? Because that has been a real cost-driver. I know, I believe in the state of Colorado we have a different from than the federal government has, you know, which is additional costs that the doctors actually have to be able to assume.

Ms. TRUDEL. This has very much been foremost in our thoughts through the entire development and standing up of this program because there are both Medicare and Medicaid incentives. And in the case of hospitals, they can qualify for both. So, we have worked very closely with the states to make sure that the requirements for both, the meaningful use requirements, are essentially identical. The web-based system that we use for registration is the same for Medicare and Medicaid. The states will handle their own attestation and payments but we communicate with the state on an online basis so that we are comparing information and making sure that we have the right providers in the right programs.

Mr. TIPTON. And Madam Chairwoman, this may take just a second more if you would allow the answer on it, but one of the other concerns that we have from the patient side is certainly the privacy issues. Are you comfortable that, you know, we are making the strides and then are going to have, I think, Dr. Mostashari had taken to it being ever vigilant in terms of making sure that we are going to be able to have the patient privacy which I think has been an obstacle for some physicians as well?

Mr. MOSTASHARI. I think that we are making strides, important strides in that direction, everything from the laws and regulations that were passed through the HITECH Act that increased protections for patient privacy. They gave patients the right to see who has looked at their information and who their information has been divulged to, which I think is going to serve an important role in providing that assurance to patients. It provides for higher penalties, civil penalties for violations, consistent violations of HIPAA. It extends the range of HIPAA to business associates, that they must follow the same security requirements as the covered entities. There are, as we mentioned, protections that we put in place under the certification program, as well as through meaningful use that security be assessed and any gaps mitigated. We are working very hard to establish a governance mechanism for health information exchange entities. These are all pieces of this and I think we will see more and more of an impact on making sure that there is more of a sense of public understanding and public comfort, that their information is if anything, more secure in electronic format than in a paper-based world where you do not know where your record is oftentimes. Records can be lost as Ms. Beutler recounted where you do not know who has looked at your record, where there is no way of limiting access to certain parts of the record. For example, the front office who maybe do not need to know all your diagnoses. So

there are important protections, but we need to be ever vigilant and we need to do everything we can to ensure that we maintain the public trust.

Mr. TIPTON. Thank you, sir. And I yield back.

Chairwoman ELLMERS. Thank you. And I would like to thank our first panel for being here today and giving us your very important insight on the adoption of health IT for small medical practices. We will continue to watch all of this, and I want to work with you on helping to reduce the barriers that small medical practices encounter.

And I would like to suggest, in regard to our second panel, if you both have staff here, if one of your staff members could remain and if you would identify those individuals to us. And again, thank you.

We will now call the second panel to the table.

Okay. I think we can go ahead and get started. And with that, I would like to say to our panel thank you very much for coming and sharing your comments and concerns with us on health IT. And I would like to yield to Ms. Herrera Beutler to introduce Dr. Sasha Kramer.

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

It is my pleasure to introduce Dr. Kramer. Dr. Kramer is a resident of southwest Washington. She serves Olympia, which is the northern part of my district on I–5, if anybody wants to know where that is. We are in between Seattle and Portland, but we are neither Seattle or Portland. Serves in Olympia and the surrounding areas in the field of dermatology. After completing a residency at Geisinger Medical Center in Danville, Pennsylvania, Dr. Kramer moved to Olympia in 2005 where she now lives with her husband and two sons. In May of 2009, she opened her own practice and has been an asset to our community ever since.

Dr. Kramer, thank you very much for coming today and we look forward to your testimony as we move forward.

STATEMENT OF SASHA KRAMER, M.D.

Ms. KRAMER. Good morning, Madam Chairwoman and distinguished members of the Committee, especially Congresswoman Herrera Beutler who represents my hometown of Olympia. As she said, Washington State.

My name is Sasha Kramer. I am a board-certified dermatologist and I appreciate the opportunity to talk to you today about health information technology and the challenges that are facing physicians surrounding the selection, purchase, and implementation of electronic health records and their practices.

So as Ms. Beutler mentioned, two years ago I opened my own practice in Olympia, where I currently employ two full-time and one part-time employee, and I see an average of 125 patients per week with 40 to 45 percent of my revenue coming from Medicare and Medicaid. Over two years ago I invested in an EHR system at a total cost of about $41,000. I did receive a $20,000 grant funded through the Washington Health Information Collaborative for Health Information Technology and paid for the remaining $21,000 out of my business cash reserves.

As a solo practitioner, I was solely responsible for the research, selection, and implementation process of the EHR vendor and sys-

tem. Initially, during system implementation my patient volume was dramatically reduced in order to accommodate the learning of the system by myself and the staff. It did take me about four weeks to return back to my normal patient schedule. However, two years later I am faced with the situation where I have to completely reinvest in a new system. Approximately one and a half years after I implemented my original system, my software vendor was acquired by another company that will not support my current network platform. Now I have no choice but to purchase a new system that will cost approximately $30,000 with $6,000 in annual charges. And aside from the financial investment, I once again have to take time away from my patients to implement and train my entire practice on this new system.

Having said this, I fully support the use of health information technology. My practice and patients benefit from HIT in a number of ways, including improved patient safety, increased practice efficiency, and simplified claims processing. While I see these as benefits in my practice, there are significant barriers to full-scale adoption and implementation of HIT, including cost, regulatory barriers, and financial penalties and system integration.

According to the American Medical Association, the average cost of an EHR system is estimated to be $30,000 per physician, with an average maintenance cost of between $3,000 and $15,000 per year. This is a significant barrier for a specialty like dermatology where over 40 percent of the practitioners are in private practice or solo practitioners and half of those are in rural areas. Physicians seeking investment capital are having issues finding a lender willing to provide them with an unsecured loan. Others may attempt to finance their HIT system purchase with the vendor, but small practices like mine have little or no leverage in negotiating the terms and rates because of a limited market share.

My practice is a great example of the unpredictable marketplace as I will have invested over $53,000, which would have been $73,000 if it were not for the grant, in two different systems over just a three-year time period.

In addition, there are regulatory burdens with financial penalties that could hurt the full-scale adoption of HIT. Dermatologists and other providers are struggling with the CMS meaningful use timeline. For early adopters who have a contract with a service provider to meet 2011 and 2012 requirements under phase one, there will be a very short window between the release of phase two requirements and the deadline for meeting them in 2013. Furthermore, physicians are facing financial penalties on their annual Medicare billables of seven percent by 2017 if they are not in compliance with the meaningful use criteria, the physician quality reporting system, and e-prescribing. This seven percent could be a practice's entire profit margin and could make the difference between a practice staying open and a practice closing. Simply understanding and implementing all of these different programs is extremely difficult and often overwhelming, especially to a small practice.

In improving HIT adoption across dermatology, I urge the Committee to address three issues. Number one, provide sufficient financial and other resources so solo physicians are able to select

and implement HIT system. Number two, consider delaying the penalties associated with HIT adoption until such a time as a functional integrational system is in place. Short of that, consider grandfathering in some physicians and exempting them from financial penalties so that they are not pushed into early retirement which could further exacerbate the physician shortage in this country. And number three, if penalties are not delayed, provide a safe harbor for those early adopters of HIT to protect them from financial penalties related to the meaningful user requirement. They should not be punished for the failure of their EHR vendor to implement new criteria.

In closing, I will absolutely continue to incorporate HIT because I see its benefits to my practice and patients, and I look forward to working with you. And thank you for the opportunity to testify before the Committee today.

[The statement of Ms. Kramer follows:]

Chairwoman ELLMERS. Thank you, Dr. Kramer. And now I will yield to Ranking Member Richmond, who is going to introduce his witness.

Mr. RICHMOND. Thank you, Madam Chairwoman.

It is now my pleasure and honor to introduce Dr. Denise Elliott, who is from Marrero, Louisiana, who practices in Marrero, Louisiana. She is a graduate of Loyola University and Barrett University of Podiatric Medicine. Dr. Elliott has served as an insurance advisor for the APMA and is board-certified by the American College of Podiatric Surgery. She has over a decade of experience as a medical specialist running her own practice. So with that I will welcome you, Dr. Elliott, and say that we look forward to hearing your testimony.

STATEMENT OF DENISE ELLIOTT

Ms. ELLIOTT. Chairwoman Ellmers, Ranking Member Richmond, and members of the Subcommittee.

I welcome the opportunity to testify before you today on behalf of myself and the American Podiatric Medical Association. I commend the Subcommittee for its focus on the vital issue of how the implementation of health information technology and electronic health records under the Medicare program will impact small medical practices.

I am Dr. Denise Lea Elliott and a member of the American Podiatric Medical Association and Doctor of Podiatry. Currently, I am a solo practitioner and the owner of the Foot and Ankle Center in Marrero, Louisiana. I know there are members of the Subcommittee who are quite familiar and supportive of the podiatric profession, but for those who may not know, today's podiatrists are physicians and surgeons licensed in the state in which they practice podiatric medicine. We are qualified by education and training to diagnose and treat conditions affecting the foot, ankle, and related structures, and provide the majority of foot care services to the Medicare population.

Podiatrists receive medical education and training comparable to medical doctors, including four years of undergraduate education, four years of graduate education at one of eight accredited podiatric medical colleges, and two or three years of hospital residency train-

ing. Most podiatrists are board certified in podiatric orthopedics and medicine or in surgery. I have been board certified in surgery since 2007.

More than 65 percent of the podiatrists in this country practice in one- or two-person groups, usually employing a very small support staff and enjoying modest annual revenues. Truly the definition of a small business. We face the same challenges confronted by all small businesses that must compete in marketplaces that do not always provide a level playing field. Podiatry practices and other small businesses can and do compete successfully against large businesses when the terms of that competition are fair. But success becomes difficult when the same demands are made upon large and small businesses with no consideration of the unique pressures placed on the small business.

Congress is to be commended for recognizing the potential value of health information technology to improve patient care and produce efficiencies that reduce costs. Chronic diseases, such as diabetes, heart disease, and kidney failure have devastating effects on patients. Many of these ailments have significant effects on the lower extremities and the feet in particular. In efficiencies abound in the treatment of such disease that could be alleviated through communication and record sharing between family physicians, cardiologists, nephrologists, vascular surgeons, podiatrists and others. Giving doctors the ability to access information on the patients they care for in real-time has the potential to significantly improve the treatment and the lives of patients.

At the same time, such communication and coordination should save the cost of duplicate tests, reduce emergency care, and hospitalization admissions, and decrease the practice of defensive medicine. The APMA fully supports this initiative that will help podiatrists provide better care for the patients they serve. However, Congress' requirement that eligible providers implement electronic health care records for Medicare over the next five years places an undue financial burden on the majority of podiatrists that are small business owners. And while we are well aware of the incentive program to encourage practitioners such as myself to adopt an EMR program, it in no way begins to take into account the great expense that a solo practitioner will incur. I do not have access to the economies of scale that work in favor of larger practices, nor do I have the opportunity to participate in a hospital cost-sharing program.

I have not yet implemented an electronic health record system in my office although I have explored and continue to explore the possibilities. In addition to the cost, I fear the effect it may have on my practice. Typical EMR implementation takes anywhere from six to eight months, and I anticipate that I will not be able to treat the same patient load during that period. To what extent will care be disrupted during the procurement and installation process? How long will it take to convert all my patient records? Will I be able to adapt to an EMR system? Will my staff? How long will it take? And while I certainly understand that an EMR system would benefit patients, will it ultimately benefit my practice? The worst thing that could happen for me and for my patients would be to lose my

practice because of the cost of implementing an EMR system that is supposed to help them.

It has been daunting to try to figure out where to start with the almost 300 certified programs listed on the ONC health information technology product list. I am affiliated with West Jefferson Medical Center, a large hospital in Marrero, Louisiana, so I decided to initially look at a product that is utilized by this hospital. It seemed logical to me to put a system in my office that would work seamlessly with my hospital system and could potentially simplify my efforts in establishing electronic health records in my practice. But I was astounded at the cost. More than $14,000 in start-up costs just for the actual electronic health record software lease. The cost for additional hardware, computers, and servers that I would have to purchase could run an additional $15,000 to $20,000. What do I do about my film x-ray equipment? I have not yet tallied the cost to purchase a digital x-ray system that would be compatible with an EMR. All of this I might add, at a time when Medicare is decreasing my reimbursements for radiology services and for physicians.

I am also evaluating other EMR options, but am consistently learning that the software purchased, installation, and training costs run approximately $25,000 to $30,000 per system, plus additional per doctor monthly fees of up to $600. In Washington, D.C., this may not seem like a big deal, but it certainly is in Marrero, Louisiana. The current Medicare incentive program offers $18,000 this year or next year if I implement an EMR program and demonstrate meaningful use for 90 consecutive days, but it appears payments in subsequent years will be significantly delayed. At first, $44,000 over five years sounded like a great deal of money but I have learned that it will not begin to cover all the costs incurred over those five years to become fully compliant with what is hoped to be a fully certifiable, reliable, and interoperable system.

EMR vendors are currently not certified beyond stage one of this three-stage meaningful use implementation plan. In fact, vendors have only temporary certification of their software programs. What happens if the vendor and product I choose is not certified for all three stages? If continuing certification is costly——

Chairwoman ELLMERS. Dr. Elliott——

Ms. ELLIOTT. Yes, ma'am.

Chairwoman ELLMERS [continuing]. I am going to interrupt you there but I am going to ask the rest of your opening statement will be submitted for the record. And just in the constraints of time. And I apologize for that because you are obviously presenting some very vital information. So thank you.

Ms. ELLIOTT. Thank you.

[The statement of Ms. Elliott follows:]

Chairwoman ELLMERS. I will now introduce our next witness, Andrew Slavitt. Mr. Slavitt is the chief executive officer of the OptimumInsight, one of the largest health information technology and consulting companies.

He has held executive positions with several other health care companies. He also worked at McKinsey and Company and Goldman Sachs. Welcome. And you have five minutes and we will be lenient with you as well.

STATEMENT OF ANDREW SLAVITT

Mr. SLAVITT. Thank you, Madam Chair, Ranking Member Richmond, members of the Subcommittee, for the opportunity to testify today on the barriers faced by small group physicians and single physician professionals in adopting and implementing health information technology.

My name is Andy Slavitt. I am the CEO of OptumInsight, and we are one of the world's largest health information technology companies with about 14,000 people worldwide. And we have worked with thousands of physicians to help them implement health information technology and help them overcome their greatest concerns—cost, uncertainty, and complexity. We have learned a lot about what works. Health doctors make the complex simple and you will see improvements in productivity and adoption. Resist the urge to support efforts even tied to financial incentives that do otherwise by adding complexity. It is not just technology adoption that is at stake; what is at stake is actually the very future of the solo practitioner in this country where costs, complexity, and uncertainty are driving consolidation into hospitals.

So to be adopted, technology must meet the needs of supporting the physician and the patient in something beneficial to them. And it can. Consider how the example of how technology could help reduce unnecessary hospital admissions. A doctor may see 40 or so patients in a day. Data suggests that only a small handful of these patients will drive the majority of costs and potential hospitalizations if not treated. Without technology, every patient looks alike until the doctor walks into the exam room. As the doctor gives our orders for a prescription, lab tests, a dietary restriction, those that go unfollowed are more likely to end up with a patient needlessly hospitalized. Without technology to help, doctors do not know who is complying and who is not until the patient shows up in the hospital even then, data suggests that doctors only become aware of this about half the time, and without the technology to trigger a follow-up visit, the chances of a longer stay or readmission to up.

All of these changes require less information technology than is used by an airline reservation clerk. In communities where this sort of technology adoption is occurring, like Grand Junction, Colorado, there is evidence that unnecessary hospitalizations, which cost us $30 billion annually, may be dramatically reduced. So I would urge us to focus on these basic things which simplify a physician's life and add more productive time to their day before we focus on more abstract requirements.

So what is it about technology that is creating these barriers? Physicians will point to several issues that have been brought up on this panel already—costs, legal uncertainty, and privacy regulations. But perhaps the greatest barrier is simpler than those. Productivity-enhancing capabilities that I describe are not today driving the purchase and design of this technology. Ironically, in a world where cloud computing, mobile technology, and social networking are creating low-cost access to a variety of capabilities for individuals and small businesses, the typical physician may tell you that the technology in their office or hospital has often become a contributor to regulatory burdens they face.

Whether meaningful use standards are right or wrong is not the real issue. What is important is that today the end-users, doctors and patients, are further away from the actual product design because new product development is focused on satisfying those regulatory hurdles of a payer, CMS, rather than on simple innovations that improve productivity.

The HITECH Act created important momentum. Approximately a third of office-based physicians are currently planning to achieve meaningful use of EHRs and apply for incentive payments this year. We need to consider that for the rest of the physician practices, the smaller ones, the temporary financial incentives will not be enough to compensate for productivity losses and private sector innovation is at work to demonstrate the power of technology where meaningful use is just the starting point.

Our company, OptumInsight offers technology, for example, with no upfront costs or maintenance required, no purchase of servers, automating the coding process for billing and collecting from health plans, and most importantly, it is instantly updatable based on the needs of the user right from the cloud. The way the world is going, we believe technology should be free. Services should cost money; technology is becoming more and more a part of the fabric of our lives.

Our written testimony offers five common sense recommendations for Congress. Allowing the requirements and regulations placed on physicians in the multitude of programs Congress oversees. Second, continue Federal investments in HIEs, which should be as essential to CMS as MMIS systems which pay Medicaid claims and administer benefits. Third, reduce uncertainty over the legal environment. Fourth, provide SBA loans, guarantees for small and solo practices and other clinicians not eligible for Medicaid meaningful use incentives. We understand this to be budget-neutral. Continue support for the Regional Extension Centers you heard about on the first panel, which are providing to be a strong tool to provide expertise to small practices which lack resources.

In conclusion, I applaud the Subcommittee for focusing attention on this issue. Physicians who practice in small practices, who were once the cornerstone of health care in most communities, are already an endangered species. In the 10 years prior to 2007, the percentage of visits to physicians who are solo practitioners decreased 21 percent. The trend has only grown more severe since. Simplifying the environment for these practices and private sector innovation should be the goal, while supporting and improving upon the efforts that got underway with the HITECH Act.

Thank you for the opportunity to testify.

[The statement of Mr. Slavitt follows:]

Chairwoman ELLMERS. Thank you, Mr. Slavitt, for your testimony, your opening statement.

I am going to introduce Dr. Baumer now, our last witness. Dr. Baumer is a professor of law and technology at North Carolina State University, which I was just there about a week ago, in Raleigh, North Carolina. Dr. Baumer has written extensively on the security and privacy of electronic medical records as well as legal liability in the information age. He received his B.A. from Ohio University, his J.D. from University of Miami, and his Ph.D. from

the University of Virginia. Welcome, Dr. Baumer. And you have five minutes for your testimony. And I will be equally as lenient with you.

STATEMENT OF DAVID L. BAUMER

Mr. BAUMER. Thank you very much. It is a pleasure to be here. Actually, it is a pleasure and an honor to address the House Subcommittee on Health Care and Technology with Congresswoman Renee Ellmers and Congressman Richmond.

I am the head of the Business Management Department at NCSU. I have a Ph.D. in economics and a law degree. I have been a member of the bar for 31 years. And within the field of law and technology, I have examined security and privacy issues. My work has been published in economic, engineering, accounting and law reviews. But enough bragging.

I delivered this speech to my wife and she said tell them what you are going to talk about and then get to it. So let me just say that I believe the written statement that I provide outside fills in a lot of the gaps relative to this PowerPoint presentation.

However, my recommendations to get right to the point are that small health care firms should be provided with safe harbors in the form of EHR software that insulates them from suit by the Federal Trade Commission, by private class actions, and by State attorney generals. Secondly, currently there is no private right of action under HIPAA, nor should there be. Third, small health care providers should not have to be IT specialists aware of the latest techniques in combating identity thieves. And fourth, a step in the right direction and I am gratified to hear this discussion, is certified software under ARRA, which creates, I would hope, a due diligence defense if somehow a cyber break-in occurs.

So finally, I would like to point out that removing legal uncertainty as we have see will not result in widespread adoption of EHR unless other obstacles are dealt with, including start-up costs and interoperability. However, going back to some of the work that I have done, we have—I have worked with people at Carnegie Mellon, Virginia Tech, Georgia Tech, examining FTC interventions on behalf of citizens' privacy and security. And the FTC has done a very good job. They are dealing with some very clever people. But what we have found and what we have discussed in the FTC's interventions is that the FTC standards for commercially reasonable security evolves from case to case. And that is because the IT technology continues to evolve.

So encryption. People talk about encryption. Forty-point encryption is no longer state-of-the-art. It is now up to 130 and it could be higher. So these interventions by the FTC create uncertainty in my opinion, even among large firms, but certainly small firms are overwhelmed.

In 2004, I wrote an article, co-wrote internet privacy law comparison between the United States and the European Union. It was apparent to me that E.U. protection of PII (personally identifying information) is much more extensive and effective than in the U.S. More recently, I co-authored an article, *Privacy and Security in the Implementation of Health Information Technology: U.S. and E.U. Compared*. Now, we start with the assumption that there will be

significant efficiency gains, but there could be some diminution in the privacy of medical records. Let me just provide you with some overall statistics.

In some E.U. countries, 90 percent plus of their medical records are electronic. In the United States it is fewer than 50 percent. And it is also true that in economic parlance there are significant and positive network externalities associated with making all medical records electronic so that there is, excuse me, an economic justification for subsidizing startup costs.

All right. I know I was supposed to confine my remarks to legal, but these things are interspersed. Let me just jump ahead and point out, for example, that HIPAA has over 15 exceptions in which medical information can be transmitted to third parties without patient consent. In the E.U., there are only three exceptions, which I would be glad to go into.

Let me cite a couple quotes and then finish up. There was a recent article in November 2010 in the New England Journal of Medicine in which it was stated the question is whether EHRs will help providers defend against such claims, medical malpractice and medical liability, or leave them more vulnerable. The answer seems to be it will do both. I am sure that is reassuring to providers.

Compliance with FTC and security protection standards necessitates firms to be cognizant of recent FTC actions which requires firms to possess substantial expertise in IT. And yet, in my opinion, security breaches are inevitable. An article written by my colleague, Professor Fay Cobb-Payton at NCSU——

[The statement of Mr. Baumer follows:]

Chairwoman ELLMERS. I am sorry, Dr. Baumer, I am going to stop you there but your testimony will be submitted for the record. And I do appreciate that insight regarding all of the security issues that we face.

And I would just further that by saying that you have highlighted an area that I think shows just some of the hurdles and barriers that we are up against, which is that technology keeps building upon itself so quickly and yet we are putting this on our physicians who are small business owners. And how can our physicians be able to incur that cost and stay up-to-date with the mandates of meaningful use as those evolve, the dollar signs. And I can speak to this on a personal level. In our practice, having had IT for probably going on about five years now, now in order for us to be compatible with meaningful use we are going to have to encounter about another $20,000. And that is for the meaningful use as it is applied now and not considering the possibilities of changes in the future.

So thank you, Dr. Baumer. I do have a couple of questions and then I will be yielding to our ranking member.

To Dr. Elliott, I know you have stated that you have not put into place your IT yet because of all of the costs that you know you are going to have to incur. One, being a podiatrist, what is the percentage of Medicare patients that you see? Or no, in relation to, I mean, if you could say how many patients you see a week and of that, if you have an idea of the percentage.

Ms. ELLIOTT. I see an average of 30 to 40 patients a day, four days a week. So 120 to 150 patients. And about 15 percent is Medi-

care. The majority of those Medicare patients are hospital-based patients, the patients with the end-stage renal disease, diabetics——

Chairwoman ELLMERS. Right.

Ms. ELLIOTT [continuing]. Being called for wounds or amputations——

Chairwoman ELLMERS. Sure.

Ms. ELLIOTT. [continuing]. Things along that line. The more severe type of foot conditions.

Chairwoman ELLMERS. So I guess the question is, and of course this is completely your opinion, is it cost effective for you to incur the cost for health IT in relation to the possibility of future penalties that you may incur? Because as you have seen as of 2015, the penalities will increase and will be sustained. Can your practice take on that penalty if you do not implement the IT?

Ms. ELLIOTT. My practice can because it is a small percentage of my practice. So that one percent then becomes two percent and three percent but it is only 15 percent of my practice. So if I was going to do a cost analysis and I had to outlay all of this money, for me it might be a better financial decision not to implement it.

Chairwoman ELLMERS. Not to implement it at all.

Ms. ELLIOTT. Correct. And my big fear is what my colleague here went through where you do spend all this money and in the future things change and you have to start over again. I already have 11,000 patients. I have to convert all those records from paper to electronic. Now I have to go with a different company and I have to convert again. Those are all costs that are involved once you convert from one system to another system because it is not ready for the second phase or it has gotten booted out or bought out by a bigger company. So.

Chairwoman ELLMERS. There again, the implementation and the changes in the technology world are really affecting us directly because, how can we comply with these issues? And that is one of our concerns. And I thank you for that.

I will now yield to Ranking Member Richmond.

Mr. RICHMOND. Dr. Elliott, I know that you did not get a chance to finish your testimony but I believe in the portion of your testimony that you did not get to talk about you talked about your concerns about meaningful use criteria. So I will ask you, consistent with what you said, that we have heard from providers who are concerned that they will not meet the ambitious definition of meaningful use goals required for stage one demonstration. And do you believe widespread adoption can be accomplished within CMS's aggressive timeline? And are there unique challenges to specialists in this area?

Ms. ELLIOTT. I think that most of the subsystems out there are designed for your primary are physicians. So as far as the specialists, I think it is a little more challenging. I think you have to go with a smaller company that is going to cater to my specialty, which will not necessarily integrate as well with the larger hospitals. Then there is interface fees. If you want to try to connect with a smaller company to a larger company. So I think it will be a challenge. I would love to see more efforts being placed on the

specialist as far as the software vendors. I think it is possible from a timeline to put this in practice, to answer that question.

Mr. RICHMOND. The other one, and this question would be for Dr. Elliott and Dr. Kramer. A lot of times, I guess, there are not clear instances of where reality and theory just do not meet. And when we talk about the incentive program, and I am curious especially for both of you as small practitioners where, Dr. Elliott, I think you said that you estimate spending $25,00 to $30,000 to implement, you may be reimbursed $18,000. And that is after a 90-day period of demonstrating use. Then four to eight week after that. Is that just a reasonable timeline or reasonable expectation to expect a small practitioner to be able to front that money and float all of the necessary bills and recoup it at the end? And at the end of that question, do you all have the access to capital to, if you do not have the money within your budget, are there lenders out there willing to lend you that money to get you through that hurdle?

Ms. ELLIOTT. Do you want to go? I know the software companies I have looked at, some of them have invested in different loaning programs. So the individual vendors have partnered with banks or loaning institutions. But now you are taking on a loan. You are taking on a business loan. It would not be a desirable thing for me as a small business owner. So, of course, it would put a kink in your cash flow if you had to outlay all this money and then wait for the timeframe for it to come back to you. So.

Ms. KRAMER. I think it is difficult for many practices. Most of the companies do give you a 12-month lease period where you divide the payments over a year. And so that makes it more manageable. But it is still a large amount of money at the beginning, which you basically just, as a small business owner, you are the last person to get paid. So you pay yourself last, you save money, and I mean, I would much rather do that than take out a business loan.

Mr. RICHMOND. And my last question, what was the decrease in the number of patients you could visit while you went through your installation and your 90-day?

Ms. KRAMER. It is very significant because it is not just me who has to learn how to use it but it is the front desk staff who has to register the patient, get the information in the system. The nurses have to enter the medications and allergies. So the first week I saw one patient an hour. And I normally see between four, six, seven patients an hour. So that is a huge—not only do you have to front the cash for the system but it is a big dip in your cash flow for the month or months. Usually it takes approximately six to nine months for a practice to get up and running fully with the system. So it took me about four to six weeks but the average, I believe, is six to nine months.

Mr. RICHMOND. Wow.

Ms. KRAMER. Yeah.

Mr. RICHMOND. According to my quick math over here, I mean, that is almost a reduction from anywhere of 75 percent to 85 percent of the number of patients you can see, which reduces your income 75 to 85 percent during this time period.

Ms. KRAMER. It is huge.

Mr. RICHMOND. Thank you.

Ms. KRAMER. And I am looking at having to do it all over again and that is really concerning. And I also mentioned that, you know, a lot of practices, especially in my field, there is a huge wait period to see specialists. I am booked five to six months out and so that just puts me even another month behind.

Mr. RICHMOND. Thank you so much.

Ms. KRAMER. Thank you.

Mr. RICHMOND. All of you.

Chairwoman ELLMERS. Thank you. And I now yield to Ms. Herrera Beutler for her questions.

Ms. HERRERA BEUTLER. Thank you. And Mr. Richmond kind of asked what I was thinking. How long is the recoup time? You know, exactly what you said. I was thinking you have to front the money upfront. You have to put the cash down and then you are not having the same revenue that you had in months previous.

Ms. KRAMER. Correct. Yeah.

Ms. HERRERA BEUTLER. So nine months? How long does it take you to break even? Did you break even up to this point and now you are having to look at another IT provider?

Ms. KRAMER. Yeah. It probably takes, I would say, to increase productivity—I mean, in my mind there is no doubt that over the long term it will increase productivity. I mean, I have fewer staff and if I had paper charts I do not have someone that has to be pulling charts, etcetera. But I think it would probably take several years to turn a profit. I would think three, four, five, six years.

Ms. HERRERA BEUTLER. So it is a long-term investment.

Ms. KRAMER. Yes, it is.

Ms. HERRERA BEUTLER. I was disappointed not to have our previous panel here. I did not know they were going to leave or I would have asked them to stay because I think it is incredibly important for them to hear. And I was trying to get at it a little bit what happens to the small and solo guys who run into a problem like this. There is no real hold harmless, I think, in a contract for you.

Ms. KRAMER. Nothing——

Ms. HERRERA BEUTLER. Is there anything that even as you are negotiating with vendors, is that something that you can require? Or do you need—or are they just going to kind of laugh at that?

Ms. KRAMER. Yeah, I asked and I asked, you know, the new vendors that I was interviewing and they said, yes, you know, our company is stable. But what does that really mean?

Ms. HERRERA BEUTLER. Thank you for that.

I wanted to also ask Dr. Baumer, I had a physician in my office a few weeks ago and they were talking to me. You kind of came at the security portion from the cyber attack side of it and you mentioned med-mal, but in terms of discoverability, I have had physicians say, look, once I put all this on line it is discoverable in a med-mal case. What is the case with paper records? And is that something you are hearing? Is it the same?

Mr. BAUMER. I do not think that there is a difference between paper records in terms of discoverability and electronic records.

Ms. HERRERA BEUTLER. You know what? Part of what he was saying was so you have this great new metrics, right, you put the information in and they can—then the computer can generate are

you looking at this? Are you looking at this? Are you looking at this? Well, a physician may be looking at certain criteria. It is probably not one of these one percent chance it is one of these other things, but if the computer brings it up there is a one percent chance and you did not go after it, is it expanding your liability exposure?

Mr. BAUMER. Well, I think that is a very good question. I mean, if the computer puts out four or five scenarios, do you have a due diligence obligation to investigate each of these? And, you know, that problem, however, has been dealt with for some time. There is kind of recommended treatment and then physicians reject that and use their own judgment. So I am not sure that because we have electronic records that that is going to be a new source of liability. But as that New England Journal points out, we do not know. And there has not been, you know, hopefully in the long run, but people cannot hold their breath in the long run, that we will have a reduction in liability. I think that most of these providers are very concerned about lawsuits from people they do not even know about issues that they are not trained about, namely IT issues, which Mr. Slavitt might be able to talk about.

Ms. HERRERA BEUTLER. Did you have a thought?

Mr. SLAVITT. Yeah. I think there is a slight difference, Congressman, and that difference is that in a paper record it may say that a patient is taking certain medication. Now, an electronic system may say because this patient is taking this medication do not give them this treatment or there is going to be a bad interaction. And so I think the fear is that that creates a level of liability. Invisibility in the liability that did not exist before. So what we obviously need to do is encourage the development of—encourage people to learn and improve and not penalize people for improving. And to self-report and so forth. That type of environment, I think, you know, will balance the needs and interests of the patient with the, I think, very real concerns of a physician to make sure that they do not get penalized for effectively trying to advance the care they are delivering.

Ms. HERRERA BEUTLER. Absolutely. Thank you. I yield back.

Chairwoman ELLMERS. Thank you. And I now yield to Mr. Hanna. Mr. Hanna, you are fine? With that I will——

Mr. Slavitt, I did have a couple of questions along the same lines of what we were just discussing. With the incredible rate of innovation in technology and the changes and all of the concerns that you have brought up, and you did an excellent job of outlining some of the areas that we need to address, with that I just want you to elaborate a little bit more on the cost and the time that it does take for our physician offices to implement this. You know, many times the software company, the vendor will say, within three months you will be up and running and you are going to turn a profit. Realistically, and I know Dr. Kramer you had outlined, you know, six to nine months. And each office is certainly going to be different based on the number of employees that will be working with it, and the time that the physician can afford to devote to it. In your opinion, are those costs and time estimates underestimated? Because that was certainly our experience.

Mr. SLAVITT. Sure. It is a great question and I think Dr. Kramer's story is really probably one of the most important cautionary tales for what can be avoided. And, you know, I think that to the extent that we think physicians and a large integrated delivery system and in Geisinger where you have come from, you have got to think of it very differently than small business, solo practitioners, who are very much—they are very much consumer professionals all at the same time. And they need to be treated differently. And so, you know, if you think about what companies like Intuit charge for practice software for a small business, for a small physician office where they have 75,000 physicians, it is very small. The training time is easy. It is a very intuitive set of applications.

Likewise, you know, I do not think there is a great future in charging individuals $75,000 to install technology in their offices and maintain it. We all know that is not the direction things are going. If you are not happy with Google, you switch to Microsoft. And if you are not happy with Microsoft, just switch to Google. That is the environment that needs to be stimulated out of ONC here. And I think there is good news and I think the kind of questions that I think need to be asked when talking to vendors are how updatable? Can it be delivered through the cloud? Can you provide guarantees that I can reach meaningful use? Can you give me a money back guarantee on the loan if I do not reach meaningful uses? And the competition—the good news is that some of the competition that has been spurred are actually driving in that direction. It clearly has not gotten out to you, Dr. Kramer, but that is what needs to happen.

Ms. ELLMERS. Thank you so much. And at that I will say thank you to our panel. This will conclude our hearing today.

This Subcommittee will continue to closely follow and take into account all of your comments and concerns, and I certainly do appreciate your time. We will be sending a letter to CMS on the e-prescribing incentive program proposed rule during the comment period that is now currently in effect.

I ask unanimous consent that members have five legislative days to submit statements and supporting materials for the record.

I have an article here that was just posted in *Medscape Medical News* and I will just briefly touch on it. Centers for Medicare and Medicaid Services, CMS, is proposing more exceptions to an electronic prescribing requirement that could penalize as many as 109,000 physicians, nurse practitioners, and other prescribers who do not adopt the technology. The title of the article is *E-Prescribing Penalty Could Hit up to 109,000 Clinicians*.

With that, this meeting is adjourned. [Whereupon, at 11:57 a.m., the Subcommittee hearing was adjourned.]

Testimony Before the
Subcommittee on Healthcare and Technology
Committee on Small Business
U.S. House of Representatives

Helping Providers Adopt and Meaningfully Use Health Information Technology

Statement of

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June 2, 2011

Good morning Chairwoman Ellmers, Ranking Member Richmond and distinguished members of the Subcommittee. I am Farzad Mostashari, National Coordinator for Health Information Technology at the Department of Health and Human Services. Thank you for giving me the opportunity to appear before you today to talk about what we are doing to support the deployment and meaningful use of electronic health records (EHRs) and other types of health information technology (health IT), especially among small physician practices and hospitals.

I know from personal experience both the importance and challenges of using better information to improve individual and population health. I began my career in health IT as assistant commissioner for the New York City Department of Public Health and Mental Hygiene.

As head of the Primary Care Information Project, we reached out to primary care practices that serve Medicaid patients, and signed agreements with over 1,700 providers in small practices, community health centers, and hospital outpatient departments to establish electronic health records systems. In New York City's three most underserved communities, over 53 percent of small practices participated in this city program. In a little more than one year, more than 1,000 providers in over 150 of these independent medical practices started live use of EHR systems with a 99 percent implementation success rate.

The project provided critical boots on the ground to implementation, and provided post-implementation technical assistance, around effective use of EHR to protect patient privacy, and improve practice efficiency, safety and quality of care. Thanks to the authorities provided by Congress in the American Recovery and Reinvestment Act of 2009 (ARRA), the Office of the National Coordinator for HIT, was able to draw on successful elements of the Primary Care Information Project as it developed the Regional Extension Center (REC) program. The REC program is a nation-wide initiative that is charged with helping 100,000 providers, especially

small and primary care practices, plan for and achieve meaningful use of EHR systems, trouble shoot problems along the way, and sustain use of those systems over time to improve patient care and outcomes.

My experience has been that providers in these kinds of small practices, as well as those in smaller hospitals, are aware of the benefits of health IT, and most would like to replace their paper-based records with a well functioning EHR system. But I also know that small practices and hospitals face unique barriers to successfully adopting EHR systems. These providers usually have less access to capital to spend on infrastructure improvements like health IT, and often lack staff with IT training and don't have the background or the time to do it themselves. Further, they feel like it is tough to choose from among the EHR systems available in the marketplace and they simply cannot afford to make a mistake in choosing an EHR system. And every provider I know, including the ones in small practices, worry about losing patient trust if the information they maintain in the EHR system does not remain private and secure.

Fortunately these barriers are not insurmountable, and ONC is committed to helping small medical practices and hospitals overcome the challenges they face in adopting and utilizing health IT.

The Benefits of Using Health IT

ONC's core mission is to improve patient care, improve health outcomes, and make the health care system more efficient through effective use of health IT.

The benefits of widespread adoption and meaningful use of health information technology are well demonstrated. Studies have shown that health IT can have measurable effects on patient safety, enabling better coordination of care, promoting better population health

management, improving efficiency, reducing medication errors, and raising overall health outcomes.

A recent article in Health Affairs looked at 154 studies examining the impact of health IT on the practice of medicine. The article found over 92 percent of the studies reached positive overall conclusions on the effects of health IT on key aspects of care, including efficiency of care, effectiveness of care, and patient safety. The authors also found that providers outside of large integrated care networks (such as Kaiser Permanente), the original innovators in health IT, are beginning to implement, evaluate, and experience benefits from health IT previously reserved for these early adopters.[i]

Health IT can also make it easier for patients to access their own health information, thus empowering them and putting them at the center of their own care. For example, patients can use health IT to retrieve their immunization records and other medical history, and automatically receive lab and test results which they can use to track progress toward a specific health goal. Health IT can also help assure that health information remains private and secure by implementing access control, auditing and encryption capabilities that limit who can access patient information to only those who are authorized to do so, keeping a record of who has accessed patient information and encrypting data when not actively in use. These critical features of HIT are difficult or near impossible to achieve in a paper-based environment.

To fully realize the potential benefits of health IT, ONC is aligning our activities with larger initiatives within the Department of Health and Human Services (HHS) and across the federal government. For instance, we are working to support the National Quality Strategy, which was announced in March and represents the first effort to create national goals and priorities to guide local, state and national efforts to improve the quality of care in the United

States. The National Quality Strategy sets out top line priorities, which include improving care for all Americans at the individual and community level and reduce the overall cost of health care services. Aligning our efforts on health IT with this initiative from the beginning will make it easier to achieve the program's aims and makes every dollar the Department invests go farther.

In addition, ONC is working on the Partnership for Patients initiative, a new public-private partnership involving HHS and hundreds of providers from around the country that focuses on improving patient safety in hospitals. The core goal of the Partnership is to improve patient safety by reducing adverse events in hospitals, and improve care transitions when patients leave the hospital. Strategic use of health IT can help providers achieve these two goals, and would have a tremendously beneficial effect on patients and their families.

Overcoming barriers to the adoption and use of health IT will also translate to job creation. The Bureau of Labor Statistics projects that number of jobs for medical records and health information technicians will grow by more than 35,000, or roughly 20 percent, from 2008 to 2018.[i] Other sources suggest that many jobs are being created among private sector firms that install and maintain EHR systems for providers. The software and tech industries are also adding jobs as more EHR products are developed and hardware is manufactured. Our experience suggests that many jobs are being created among private sector firms that install and maintain EHR systems for providers. The software and tech industries are also adding jobs as more EHR products are developed and hardware is manufactured. Much of this job creation seems to have happened in small businesses since 60 percent EHR products certified to date by certification bodies authorized by ONC have been developed by companies with 50 or fewer employees. As mentioned earlier, ONC has initiated a multi-faceted training program that is

helping to prepare skilled health IT professionals, including curriculum development, competency exams, and training.

ONC's Role in Supporting the Adoption and Meaningful Use of Health IT

The important role health IT can play in improving health care quality and reducing costs was recognized by the previous administration, when the ONC was established by Executive Order 13335 in 2004. The order directed ONC, "to provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care..."

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was part of ARRA, included specific authorities for ONC. The Recovery Act provided a direct appropriation of $2 billion to support ONC's mission and created the Medicare and Medicaid EHR Incentive Programs that provides direct payments to eligible doctors, hospitals and certain other eligible professionals who adopt, implement, upgrade and meaningfully use certified EHR technology.

ONC works with several other components of HHS in implementing provisions of the HITECH Act. ONC has the lead role in administering various programs funded by the $2 billion appropriation and the Center for Medicare & Medicaid Services (CMS) has the lead role in administering the Medicare and Medicaid EHR Incentive Programs. The two agencies work in tandem and the efforts of each directly support and complement the other. An illustrative example of the ONC and CMS collaboration is the development of both the policy and technical standards for meaningful use Stage 1, and the process of considering the policies and technical standards for meaningful use Stage 2, which we are currently engaged in drafting.

In pursuing its work, ONC strives to remain as transparent as possible and listens to input through a wide variety of channels. Our work is highly informed by two standing Federal Advisory Committee Act (FACA) committees established by the HITECH Act: the HIT Policy Committee and HIT Standards Committee. These two committees are comprised of dozens of health IT experts from a variety of fields and backgrounds, from both government and the private sector.

Since their inception in 2009 through May 16, 2011, these committees, their subcommittees or working groups, have met publicly 340 times, an average of almost one meeting every other day. What is perhaps most incredible about this statistic is that the people who serve on these committees are not paid for their work, but nonetheless dedicate an enormous amount of time and energy toward providing advice about how to maximize health IT's impact on improving care and efficiency.

I would be happy to talk in more depth about all of ONC's activities, but in the interest of time I will summarize our major initiatives.

The Health IT Regional Extension Program

ONC is spending $774 million to help fund a nation-wide network of 62 Regional Extension Centers (RECs) and the Health IT Research Center (HITRC). Our regional extension center program offers providers training, information, and technical assistance to accelerate the adoption and meaningful use of certified EHR technology. Each REC is independent and is usually operated by a local non-profit or consortium to meet the needs of the community and region they serve. The particular focus of RECs is helping primary care providers, small practices, critical access hospitals, and other undeserved or under-resourced providers achieve meaningful use.

The Health IT Research Center provides technical assistance and develops best practices for the regional centers for the implementation, adoption, and effective use of health IT.

As of May 24, the REC program has enrolled 70,481 providers, 94 percent of whom are primary care providers and 38 percent of whom are small physician practices with fewer than 10 doctors. While every REC is focused on helping small practices overcome barriers to adoption and meaningful use of EHR technology, here are several noteworthy examples of what is being done in the field:

- The Georgia and Massachusetts RECs are working with commercial banks to help providers secure loans for hardware/software;
- The REC in Los Angeles is assisting all of the small provider practices it has enrolled to conduct project management of the EHR implementation process and is working directly with vendors to mitigate problems that are identified;
- The Ohio REC has developed an extensive needs assessment that proactively identifies any potential barriers to implementing EHR systems at the start of the process. The uses the needs assessment with the provider to address any issues before going live;
- The Arizona REC is working closely with the Community College workforce programs in the state to give internships to students and place them in small practices. The Academic Program Development at community colleges focus on positions that require three to six months of intensive training. Individuals are trained in the mobile workforce and permanent staff positions: implementation support specialists, practice workflow and information management redesign specialists, clinician consultants, implementation managers, technical/software support staff, and trainers. These

positions that were identified as the areas where the largest numerical need exists – approximately 41,000;

- The REC in Minnesota/North Dakota is holding a series of Meaningful Use "Boot Camps" to educate providers, especially those in small practices, about what they need to do to achieve meaningful use; and
- A group of REC experts in privacy and security helped to develop a privacy/security check list that RECs are now using to assist small practice providers to protect their EHR Systems.

The State Health Information Exchange Cooperative Agreement Program

ONC has awarded $564 million through 56 grants to all fifty states, the District of Columbia and five U.S. territories to rapidly build the infrastructure for exchanging health information across the health care system both within and across states. These grants are designed to mobilize health information exchange capabilities to support providers in achieving meaningful use, including through technology infrastructure, shared services, and standards adoption. Many states are using the Nationwide Health Information Network (NwHIN), to conduct simple, secure messaging of health information between providers utilizing an email-based protocol identified under an ONC initiative. This will give all providers --- whether they practice in rural clinics, small practices or urban hospitals --- easy-to-use health information exchange options to enable rapid progress in meeting meaningful use requirements and improving patient care this year. We are also working to close the gaps in health information exchange capabilities by developing strategies to make sure every eligible provider has at least one option for exchanging health information that meets the requirements of the Medicare and Medicaid EHR incentive programs.

The Health IT Workforce Development Program

ONC is providing $118 million to four different programs to train the health IT workforce of the future. Due to the rapidly increasing demand for health IT products and services, it is projected there will be a shortfall of 51,000 health IT workers over the next four years, which creates job opportunities for well trained workers. Small physician practices, clinics and hospitals are among the groups most adversely affected by this shortfall, since they usually have few if any IT workers on staff and can find it difficult to hire knowledgeable workers to install and support their health IT systems. ONC has worked to address this situation by funding education programs at 82 community colleges across the country where training can be completed in six months or less, accompanied with help with job placement, as well as providing support for nine university-based programs that provide training at the post-baccalaureate and master's level. ONC is also providing funding to, Oregon Health & Science University, University of Alabama at Birmingham, Johns Hopkins University, Columbia University and Duke University, to develop high quality instructional materials to support training of the health IT workforce. Developed initially for use by our funded community colleges, these materials will soon be made available to all institutions of higher education that wish to establish health IT programs.

So far, over 2,400 students are expected to have graduated from the community college training programs by the end of May, and another 4,700 are currently enrolled and receiving training. The graduates produced by these programs represent a down payment on ONC's commitment to close the workforce gap and help ensure that providers and others have access to a well-trained workforce.

The Beacon Community Cooperative Agreement Program

ONC has awarded $265 million in grant funding to 17 Beacon Communities throughout the United Sates, ranging from Maine to Hawaii. The program goals include building and strengthening a health information technology infrastructure; improving health outcomes, care quality, and cost efficiencies; and spearheading innovations to achieve better health and health care. In the first year of the program, the Beacon Communities established foundational structures and partnerships in governance, clinical transformation, health IT, and measurement tools. Now, they are implementing IT-enabled clinical interventions and public engagement tools to improve health and health care. Beacon Communities are increasingly disseminating key implementation insights with others in the country developing regional approaches to transform the health care system, one community at a time.

Amongst several other interventions, the Southern Piedmont Beacon Community in North Carolina is using IT systems that support care managers working with individuals with chronic conditions, thus reducing unnecessary emergency department visits and avoidable expenses. The Crescent City Beacon Community in the New Orleans area is optimizing clinical decision support tools and improving processes in the community clinic and hospital settings, especially around diabetes care.

Certifying EHR Systems, Coordinating Federal Health IT Activities, and Protecting Privacy & Security

In addition to funding these important grant programs, ONC also supports other initiatives to facilitate the nationwide adoption and use of health IT.

ONC is at the center of federal efforts to establish standards for EHR systems and let providers and the public know which EHR systems are meeting these standards. In close

conjunction with our two Federal Advisory Committees, ONC identified standards to enable secure health information exchange, or when those standards did not exist for health care, convened industry organizations, consumer groups, federal agencies, and other stakeholders to develop new standards.

These standards form the basis of the program and processes for testing and certifying EHR systems. We currently have six authorized private-sector certification bodies which have certified more than 735 separate EHR products. Of these certified EHR products, 60 percent have been developed by small businesses with 50 or fewer employees, and 87 percent of these businesses have less than 200 employees. This incredible statistic validates ONC's approach to encouraging the adoption of health IT: set out some basic rules for everyone to follow, level the playing field, provide incentives where more progress is needed, and step out of the way to let the market do the rest. This approach is leading to the development of innovative EHR products that are easier for small practices to implement and less expensive than ever before.

As part of the effort to promote electronic information exchange and interoperability and to add functionality to the NwHIN, ONC used its platform to initiate the Direct Project. Launched in March 2010, the Direct Project was charged with arriving at standards to support the secure exchange of clinical health information between providers using a simple, email-based approach. The Direct Project used a unique approach that invited the greater health IT community to identify, develop and select a standard that met their needs. Within 10 months, the groups working on the project had demonstrated the success of this email-based approach to information exchange, and 12 months later more than 60 HIT vendors committed to incorporating the Direct Project's standards for health information exchange. Providers may use the Direct Project's transport standards to meet the Stage 1 meaningful use incentive payment

program requirement for exchange of clinical information. For instance, a primary care physician can use these standards to transmit a clinical summary of a patient to a specialist and receive a summary of the consultation.

The innovative approach to arriving at the standards used by the Direct Project will continue to evolve as we bring the health IT community together to expand the functionality of the NwHIN and modernize the way health information is exchanged. For instance, this way of leveraging skills across the health IT landscape is now being used to identify standards to support better ways of providing laboratory information to providers, and arrive at a standardized way of exchanging key clinical information when patients transition out of a hospital stay.

ONC is also charged with coordinating health information technology activities throughout the Department of Health and Human Services, as well the rest of the federal government. In carrying out this mission, ONC chairs or serves on numerous committees, coordinating councils, working groups, and task forces.

One of these groups is the Federal Health Information Technology Task Force, which ONC co-chairs with the Office of Management and Budget, and involves numerous other federal agencies, including CMS, Department of Veterans Affairs, Social Security Administration, Department of Defense, Department of Commerce, Department of Agriculture, and the Office of Personnel Management. The overall goal of the Task Force is to promote communication and information sharing between different federal agencies who are each involved with health IT while adhering to high standard of privacy and security. Through this forum, agencies that might not otherwise be communicating or interacting with one another have the opportunity to learn from what others are doing, align toward common policy goals, and reduce potential overlap and redundancy.

Another important activity we are engaged in is ensuring that health information remains safe and secure when it is in digital form. Leading this effort at ONC is the Chief Privacy Officer, a position that was created by the HITECH Act. ONC's Chief Privacy Officer works in partnership with other divisions in HHS, as well as other agencies throughout the federal government to coordinate efforts to protect privacy and security of electronic health care information. We work especially closely with the Office for Civil Rights, which is the entity within HHS that is responsible for enforcing the protected health information privacy, transactional, and security rules established under the Health Insurance Portability and Accountability Act (HIPAA).

ONC has taken a number of important steps toward making electronic health records private and secure. Last July, ONC issued its standards and certification final rule, which specifies that in order for an EHR to be certified, it must be capable of encrypting electronic health information. We are analyzing breach notifications reported to the Secretary pursuant to the HITECH Act, have identified security vulnerabilities and are taking affirmative steps to address them. For example, ONC is working with the National Institute of Standards and Technology to explore the technical means of building more security into EHRs to make protecting information as seamless and easy as possible for providers. And lead by the University of Illinois at Urbana-Champagne, ONC's Strategic Health IT Advanced Research Program is developing innovative technologies and policies to reduce privacy and security risks to electronic health information.

In addition, a core part of Stage 1 of the meaningful use incentive program is a requirement that providers conduct a security risk analysis of their EHR system, implement security updates and correct identified security deficiencies as part of its risk management

process. As ONC and CMS look ahead to requirements for Stage 2 and Stage 3 of meaningful use, we are working closely with the HIT Policy Committee, States, a number of healthcare associations, healthcare providers, consumer advocates, and other representatives of the health IT industry to explore additional requirements that will ensure adequate privacy and security protections for protected health information, or PHI.

We are also in the process of revising ONC's 2008 National Privacy and Security Framework. Our aim is to create a framework where patients and providers are assured every appropriate step is taken to protect patient information, while permitting data to flow easily enough to effectively coordinate care and support quality improvement efforts. To this end, we have established a process for obtaining and reviewing recommendations on priority privacy and security issues from our HIT Policy Committee with the goal of resolving these key issues by the end of the year.

ONC has also built privacy and security into all of its programmatic efforts, from providing technical assistance to Regional Extension Centers and State Health Information Exchange fund recipients, to reviewing curriculum for new HIT training to ensure that the future generation of technical workers is well grounded in privacy and security.

Health IT Implementation

A necessary first step in realizing the full potential of health IT is to help providers to adopt and meaningfully use certified EHR technology. The concept of meaningful use is central to the health IT provisions that were included in the HITECH Act. ONC and CMS have worked closely over the last two years to develop and implement the Medicare and Medicaid EHR

incentives program. My colleague from CMS will talk about the meaningful use program in more detail.

The HITECH Act recognizes that if all we do is put an EHR in every provider's office or hospital, we will have failed to realize health IT's full potential. Instead, doctors, hospitals, and other providers need to use robust EHR technology in a meaningful and interoperable way to improve care.

The Medicare and Medicaid EHR Incentive Programs are premised on the fact that even though electronic health record systems have been shown to enable better patient care, better overall outcomes, and can make care much more efficient, adoption of robust EHR systems have been persistently low. As recently as 2008, 12 percent of hospitals and just 17 percent of office-based primary care physicians reported using a basic EHR system.[ii] Since the passage of HITECH, we have started to see those figures rise dramatically. Last year, 19 percent of hospitals and 30 percent of primary care doctors – more than a 50 percent increase in two years – reported using a "basic" EHR.[iii] By these measures, we are approaching a tipping point where EHR systems become commonplace and the entire health IT marketplace becomes truly self-sustaining.

The Medicare and Medicaid EHR Incentive Programs are designed to stimulate adoption and use of EHR, but I must emphasize this program is not about technology for its own sake. It is about getting providers and hospitals to use electronic health systems as a tool to help bring about transformational improvement of the health care system. This is where health IT becomes part of a "virtuous cycle" to improve care, which in turn leads to more innovation and development.

There are plenty of ideas about how to improve the way care is delivered, including disease registries, accountable care organizations, patient-centered medical homes, bundled payments, and decision support tools. But I would maintain that an absolutely essential component to making any of these strategies work effectively is they must be supported by the robust use of health IT.

ONC's Strategic Plan for the Future

Through the implementation of the Affordable Care Act, the next several years will be pivotal for the future of our health care system and ONC is committed to doing everything we can to ensure that health IT supports the fundamental goals of better care, improved health, and reducing the cost of care.

ONC recently laid out a vision for the future in our draft Federal Health IT Strategic Plan for 2011-2015 and is in the process of analyzing and addressing public comment on it. As outlined by the Federal Health IT Strategic Plan, ONC has identified six underlying principles that will guild our ongoing work to unlock the vast promise and potential of electronic health information to transform, modernize and improve the way care is delivered. We are committed to putting patients at the center of everything we do by enabling patients to get access to their own health information, participate effectively in their own care, and by making sure sensitive information health remains private and secure.

- We will remain open and transparent, listening to input and advice from a wide variety of voices.
- We will rededicate ourselves to excellence in implementation, selecting ambitious but achievable goals, learning from experience, and adjusting as we go.

- We will continue to address the unique challenges faced by those with fewer resources, such as small practices and community access hospitals.
- We will continue to work hard to foster innovation by finding the right balance between standards that make health IT's benefits possible, while preserving potential for new, sustainable approaches.
- And we will keep our eyes on the goal of promoting use of health IT as a tool to help deliver better, safer, more efficient care, not as an end in itself, but to improve patient health.

Conclusion

Health information technology is a critical part of the foundation that supports efforts to modernize and transform our health care system. Now is the time to get down to the hard work of implementing and using health IT in a way that leads to better, less expensive care, and I am proud of the role ONC plays in achieving that goal. Thank you for giving me the opportunity to appear before you today. I look forward to continuing to work together and answering any questions you may have.

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[iii] The US Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. Fiscal Year 2012 President's Budget Request to Congressional Appropriations Committees, Online Performance Appendix, FY 2010 Performance Report, FY 2012 Performance Plan. Available online at: http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_11673_953471_0_0_18/Online-Performance-Appendix-021411.pdf (accessed 23 May 2011).

[iii] Ibid.

STATEMENT OF

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CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAMS

BEFORE THE

U.S. HOUSE COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON HEALTHCARE AND TECHNOLOGY

JUNE 2, 2011

CMS TESTIMONY

Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs

U.S. House Committee on Small Business

Subcommittee on Healthcare and Technology

June 2, 2011

Chairwoman Ellmers, Ranking Member Richmond, and Members of the Subcommittee, thank you for the invitation to discuss the impact of the implementation of Health Information Technology (HIT) on small and solo providers, especially the implementation of the Centers for Medicare & Medicaid Services' (CMS) new incentive program for electronic health records (EHRs). My testimony will focus on explaining the different components of the Medicare and Medicaid EHR Incentive Programs and how these programs encourage the widespread adoption of EHRs, as well as CMS' progress in helping providers implement and meaningfully use EHRs. CMS and States are now providing incentive payments to 1139 eligible professionals and 110 eligible hospitals that have successfully adopted, implemented, upgraded, or demonstrated meaningful use of EHRs under the Medicare and Medicaid EHR Incentive Programs.

Background

Through the Health Information Technology for Economic and Clinical Health (HITECH) provisions within the American Recovery and Reinvestment Act of 2009 (ARRA) (P.L. 111-5), Congress established the Medicare and Medicaid EHR Incentive Programs to provide incentive payments to eligible professionals and eligible hospitals (including critical access hospitals (CAHs)) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. Since enactment, CMS and HHS' Office of the National Coordinator for Health Information Technology (ONC) have been laying the groundwork to support this national investment in EHRs. Both CMS and ONC published regulations providing a roadmap to eligible professionals and eligible hospitals about what they would need to do to qualify for the EHR incentive payments and ONC's Regional Extension Centers provide direct assistance to providers seeking to select and implement EHR technology.

Widespread adoption and meaningful use of EHRs and health information exchange are expected to improve health care quality for patients by increasing the information available to individual providers, enhancing provider coordination, and reducing unnecessary health care costs that come from items such as duplicated tests or preventable drug errors. While early in implementation, the EHR Incentive Programs are already helping to bring our health care system into the 21st Century. By promoting the adoption of EHR and health information exchange, health care providers will have powerful tools to improve health care. EHRs have the potential to:

- Increase patient safety by identifying preventable safety concerns such as alerts that warn providers when a new prescription will interact with another medication the patient is taking.
- Further care coordination by making a patient's complete current health information more easily available and eliminate the need to duplicate diagnostic tests;
- Advance care by delivering outputs that paper records cannot;
- Enhance patient and provider convenience by providing more informational resources and follow-up instructions for patients, allowing physicians to e-prescribe, and reducing paperwork time for providers;
- Improve patient privacy and security over paper records – rules based access can limit who has access to specific information based on their job, and robust audit trails can track and provide information for patients on who accessed or changed a particular record.

With improvements that reduce administrative burden, enhance patient safety, reduce duplicative tests, and progress toward high quality effective care, we are confident that the meaningful use of EHRs will be a powerful tool to help providers deliver better care more efficiently– one of CMS' main goals in transforming the health care delivery system.

However, I want to be clear that EHRs do not achieve their many benefits merely by transferring information from paper files into digital form. EHRs can only deliver their maximum benefits when the information is standardized and structured so that it can be used to provide an

additional knowledge base to providers at the point of care, and also allow multiple health care providers to exchange health information, known as interoperability. Therefore, CMS and ONC require providers to meet specific objectives and to use EHRs that are certified specifically for this program in order to receive incentive payments. The HITECH provisions define which health care professionals and hospitals may be eligible for the EHR Incentive Programs and the differences between the Medicare and Medicaid EHR Incentive Programs. The HITECH Act also grants HHS the authority to determine the standardized criteria for how EHRs should function and how professionals and hospitals should use EHRs in a meaningful way. ONC defines the standards and certification criteria for EHR technology and information exchange. CMS defines the criteria for what a meaningful user of EHR technology is and how providers must demonstrate their meaningful use to CMS and to States. By coordinating our respective regulations, CMS and ONC are ensuring that the incentive payments are received for adoption and use of EHR systems that actually improve care and will lower unnecessary health care costs.

The Medicare and Medicaid EHR Incentive Programs

The following section provides an overview of the key components and differences between the Medicare and Medicaid EHR Incentive Programs. Eligible professionals, including small practitioners, who meet the eligibility requirements for both the Medicare and Medicaid EHR Incentive Programs may participate in only one program and must designate which program they choose to participate in. Eligible hospitals meeting all requirements for the Medicare and Medicaid EHR Incentive Programs can receive payments under both programs. Because the programs are so closely related, we established the same rules, requirements, and procedures for both Medicare and Medicaid wherever possible.

Medicare EHR Incentive Program

The Medicare EHR Incentive Program provides incentive payments to eligible professionals and eligible hospitals that demonstrate meaningful use of certified EHR technology for a defined reporting period (90 days in the first payment year, a full year in subsequent years).

- Eligible professionals, including small and solo providers, can receive up to $44,000 over five consecutive years under the Medicare EHR Incentive Program. There is an additional incentive payment for eligible professionals who provide more than fifty percent of their covered services in a designated Health Professional Shortage Area (HPSA).
- To qualify for the maximum incentive payment, Medicare eligible professionals must begin participation by 2012, as the first year payment amount diminishes starting in 2013.
- Incentive payments for eligible hospitals are based on a base payment of $2 million combined with an additional computation based on the number of acute care inpatient discharges a hospital has that year which is then multiplied by a "Medicare share," which is calculated using the percentage of the hospital's acute care inpatient bed days paid by Medicare with an allowance for charity care. To qualify for the maximum incentive payment, hospitals must begin participating by 2013; hospitals may begin receiving payments in 2014 or 2015 but they will receive a lesser total payment.
- In 2015 and later years, the law includes a negative payment adjustment in Medicare reimbursement for Medicare eligible professionals and eligible hospitals that do not successfully demonstrate meaningful use.

The HITECH Act defines a Medicare eligible professional as a doctor of medicine or osteopathy, dental surgery or dental medicine, podiatric medicine, optometry, or a chiropractor, who is legally authorized to practice under State law. However, eligible professionals who are hospital-based (as defined in regulation as, those who furnish 90 percent or more of covered professional services in the inpatient hospital or emergency department settings) do not qualify for the incentive payments, and therefore, are not subject to the payment adjustment. Certain professionals who are employed or subcontracted by a Medicare Advantage (MA) organization and who provide an average of at least 20 hours of patient care services per week to enrollees of the MA organization may also be eligible for incentive payments.

The HITECH Act states that an eligible hospital for Medicare EHR incentives is a "subsection (d) hospital" that is paid under the hospital inpatient prospective payment system and located in

one of the 50 States or the District of Columbia. CAHs are also eligible for Medicare incentive payments.

Medicaid EHR Incentive Program

The Medicaid EHR Incentive Program will enable states to provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. Under the law:

- Individual States and Territories voluntarily offer the Medicaid EHR Incentive Program. All states have indicated that they plan to do so. Eligible professionals, including small and solo practitioners, can receive up to $63,750 over the six years that they choose to participate in the program, with initial payments beginning no later than 2016. They can receive $21,250 in the first year.
- The last year a Medicaid eligible hospital may begin the program is 2016. Hospital payments are based on an estimation of the total amount that would be available under a similar formula as that used in Medicare, except using a "Medicaid" rather than Medicare share, which is based on acute-care inpatient bed days paid by Medicaid. The States can then determine how quickly the total amount is disbursed as long as this timeframe is at least 3 years and no more than 6 years.
- There are no payment adjustments mandated under the Medicaid EHR Incentive Program for providers that do not demonstrate meaningful use.

While the State expenditures for incentives are eligible for 100 percent Federal matching payments, States are required to plan for and administer the program with a 90 percent Federal match for approved costs. To qualify to receive 90 percent Federal matching funds for State costs associated with administering the Medicaid EHR Incentive Program, States must develop:

- Health Information Technology Planning Advance Planning Document (HIT PAPD) – A plan of action requesting Federal matching funds and approval to accomplish the

planning necessary for a State Medicaid agency to implement and oversee the EHR Incentives.

- State Medicaid Health Information Technology Plan (SMHP) – A landscape assessment describing the State's current and future HIT activities, as well as the activities in support of the Medicaid EHR Incentive Program.
- Health Information Technology Implementation Advance Planning Document (HIT IAPD) – A plan of action requesting Federal matching funds and approval to implement and oversee the EHR incentive payments.

Under the terms of the HITECH Act, Medicaid has a more expansive definition of eligible professionals and allows not only physicians, but also nurse practitioners, dentists, certified nurse-midwives, and certain physician assistants (when the physician assistant is practicing at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) led by a physician assistant), to qualify for incentive payments. Medicaid incentives are also available for acute care hospitals, which include cancer hospitals, general short-term stay hospitals and CAHs, as well as, children's hospitals. Eligible professionals and most eligible hospitals are subject to a requirement that some portion of their patient volume is derived from treating vulnerable populations. In general, Medicaid eligible professionals may participate in the program when they: 1) have at least 30 percent of their patient volume derived from Medicaid (20 percent for pediatricians); or 2) practice predominantly in an FQHC or RHC and have 30 percent of their patient volume derived from needy individuals. Acute care hospitals must have 10 percent of their patient volume derived from Medicaid patients. Only children's hospitals have no patient volume requirement.

EHR Incentive Program "Meaningful Use" Final Rule

As explained earlier, the HITECH Act defined certain aspects of the Medicare and Medicaid EHR Incentive Programs, but granted HHS the authority to define other standardizing criteria. CMS defined, through a notice-and-comment rulemaking process, what it means to "meaningfully use" certified EHR technology and how professionals, including small and rural

providers, and hospitals can demonstrate their meaningful use; the final rule was published on July 28, 2010 (CMS-0033-F). The following sections summarize the meaningful use provisions of this rule.

Meaningful Use Criteria and Clinical Quality Measures

EHRs cannot achieve their full potential if providers do not fully utilize the capabilities they bring. Therefore, the "meaningful use" approach requires providers to meet specified objectives and measures in order to qualify for incentive payments. In order to maximize the potential of EHRs, we adopted an "escalator" approach to meaningful use, in that we envision three Stages, each requiring more rigorous requirements. The first stage focuses on using EHRs to collect clinical data, begin implementation of Computerized Provider Order Entry (CPOE) and electronic prescribing, and taking initial steps to move toward patient engagement and secure electronic exchange of clinical data. The remaining stages, which will be defined through rulemaking, plan to incorporate robust clinical decision support, widespread secure electronic data exchange, care coordination and full patient engagement. Privacy and security requirements are required in all stages of the program.

The announcement of final "meaningful use" regulations provided a critical component in our efforts to speed EHR adoption and use. ONC simultaneously issued a closely related final rule that defines an initial set of standards, implementation specifications, and certification criteria for EHRs. ONC issued the final rule setting up a temporary certification program for health IT on June 24, 2010, (75 FR 36158), and the final rule setting up a permanent certification program for health IT on January 7, 2011, (76 FR 1262).

Stage 1 Criteria for Meaningful Use and Clinical Quality Measures

The Stage 1 criteria for meaningful use focus on electronically capturing health information in a standardized format, using that information to track key clinical conditions, securely communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information. The criteria for meaningful use are

based on a series of specific objectives, each of which is tied to a measure that allows eligible professionals and eligible hospitals to demonstrate that they are meaningful users of certified EHR technology.

For Stage 1, there are 25 objectives for eligible professionals and 24 objectives for eligible hospitals. The objectives have been divided into a "core" set and a "menu" set. Eligible professionals and hospitals must meet all objectives in the "core" set (15 for eligible professionals and 14 for eligible hospitals). They can choose to defer up to five remaining objectives (other than certain required public health measures) in the "menu" set. CMS evaluated each objective for its potential applicability to all eligible professionals and hospitals. In instances where it is impossible for an eligible professional or hospital to meet a specific measure, the regulation allows for exclusion, in which case the professional or hospital does not have to meet that objective in order to be determined a meaningful EHR user. For example, if an eligible professional has two exceptions (one for a core objective and one for a menu objective); the professional would need to meet the remaining 14 objectives in the core set and four of the remaining nine objectives in the menu set. We added this flexibility in response to public comment that strongly recommended that we accommodate the various levels of EHR implementation in order to facilitate participation by providers who did not have robust EHR implementations. This flexibility should be especially important for small providers that are just embarking on the process of selecting and implementing EHR technology.

One of the core meaningful use objectives is to report clinical quality data to CMS or the States. CMS promulgated final clinical quality measures in its July 28 final rule. For eligible professionals, there are core and menu set clinical quality measures. Eligible hospitals must report on a core set of clinical quality measures. In 2011, eligible professionals and eligible hospitals will submit aggregate numerator, denominator, and exclusion data for each such clinical quality measure to CMS or the States. In the future, eligible professionals, eligible hospitals, and CAHs seeking to prove meaningful use will be required to electronically submit clinical quality measures selected by CMS directly to CMS (or the States for Medicaid) through certified EHR technology. CMS recognizes that for clinical quality reporting to become routine,

CMS must reduce the administrative burden of reporting. The burden will be reduced when registrants use certified EHR technology to securely report information on clinical quality measures electronically to a health information network, a State, CMS, or a registry. CMS expects that by their second implementation year, States will have the capacity to accept direct submission of Medicaid providers' clinical quality measures from certified EHR technology.

EHR Incentive Program Status

Less than a year after publishing the final rule, CMS is now providing incentive payments to eligible professionals and hospitals that have successfully adopted, implemented, upgraded or demonstrated meaningful use of EHRs under the Medicare and Medicaid EHR Incentive Programs. As of May 2011, more than 42,600 eligible professionals and hospitals registered for either the Medicare or Medicaid EHR Incentive Program and more than 9,100 people have subscribed to the EHR listserv, which updates subscribers about new materials and resources for the EHR Incentive Programs. We have developed a web-based application for providers to register for both the Medicare and Medicaid incentive programs. The web-based application also helps CMS keep track of which providers have selected and received incentive payments from which program. The same application is used for Medicare providers to attest to their meaningful use of EHRs. States will develop their own attestation mechanisms, and data is exchanged bi-directionally between CMS' central database and the States.

Medicare Status

On January 3, 2011, registrations both for the Medicare and Medicaid EHR Incentive Program began and 42,393 professionals and 221 hospitals have registered for the program through April 30. Attestation for the Medicare EHR Program successfully opened on April 18, 2011; already, 485 providers and hospitals have successfully attested during this first month, and CMS expects this number to continue to grow over the duration of the program. To attest for the Medicare Program, professionals, hospitals, and CAHs must have registered for the program, and must have reported on their meaningful use of certified EHR technology for the 90-day reporting period. The first EHR incentive payments went out to meaningful users on May 19, 2011, and

CMS paid $5,094,000 in incentive payments to eligible professionals that attested to meaningful use and $70,762,912 in incentive payments to eligible hospitals that attested to meaningful use. Eligible hospitals and CAHs may begin their attestation period as late as July 3, 2011, and eligible professionals may begin as late as October 1, 2011.

Medicaid Status

CMS is encouraged that States across the country have already shown strong enthusiasm for the EHR incentive program. States began launching their Medicaid EHR Incentive Payments Programs in January 2011. Eleven States – Alaska, Iowa, Kentucky, Louisiana, Michigan, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas – began their programs on day one. Since then, Alabama, Missouri, Indiana, and Ohio have begun EHR registration for Medicaid providers, bringing the total number of states participating in the program to 15. The majority of states have indicated to CMS that they will launch by the end of calendar year 2011. Of the States that have launched programs since January, many have already started making payments. Kentucky, Iowa, Oklahoma, and Louisiana launched their program in January and started making payments within days. Louisiana made the first EHR incentive payment in the country to eligible professionals, who are safety net providers at Winn Community Health Center. Kentucky paid the first hospitals in the country, Central Baptist Hospital and University of Kentucky Hospital, which is a teaching hospital. Oklahoma paid the first eligible professionals at the Gastorf Family Clinic, a small, independently-owned primary care clinic in Durant, Oklahoma. As of May 4, CMS and the States have paid out over $83 million in Federal matching for incentives through the Medicaid EHR incentive program.

Outreach

CMS strives to increase awareness and participation in the Medicare and Medicaid EHR Incentive Programs, as well as increase stakeholder support for the programs. CMS uses a variety of tools to engage eligible providers, including small and solo providers, hospitals, and States in the programs, including social media, print and web advertisements, articles in trade magazines and blogs including WebMD's Medscape, and professional conferences. This

strategy focuses on making high quality information easily accessible to busy providers. CMS has established a website at www.CMS.gov/EHRIncentivePrograms where providers can access frequently asked questions, and other materials that make registering for the programs and attesting to meaningful use easier, such as step-by-step guides, factsheets in English and Spanish, and web tools like the Meaningful User Calculator.

CMS has held webinars and conference calls to teach and inform potential and current registrants about the EHR Incentive Programs. For example, three webinars in August 2010 that provided an overview of the program had over 9,000 participants. A registration webinar on February 18, 2011, attracted 2,556 participants. On April 1 and April 6, CMS sponsored two national provider sessions on registering for the programs which had 2,998 and 1,701 participants, respectively. On May 3 and May 5, CMS also sponsored two national provider sessions on attestation which had 1,116 and 3,132 participants, respectively. CMS also conducted several educational sessions at the Healthcare Information and Management Systems Society, one of the largest annual healthcare information technology conferences in the country. Through those sessions, CMS was able to reach thousands of eligible professionals and representatives from eligible hospitals. CMS continues to conduct educational sessions as national association meetings around the country.

CMS also focuses its outreach efforts regionally. On April 6 to April 8, Dallas team members, from the CMS regional office, participated as exhibitors at the annual conference of the Texas Organization of Rural & Community Hospitals. They provided information about the EHR Incentive Programs to the region's small and rural providers. On April 12 and 13, San Francisco team members conducted five State-specific webinars for eligible professionals in California, Nevada, Arizona, Nevada, Hawaii, American Samoa, and Guam, to discuss the EHR Incentive Programs. Each webinar or call featured speakers from the Regional Extension Centers and State Medicaid Offices.

Throughout the implementation of the program, CMS is engaging in frequent outreach activities to educate the States on the Medicaid EHR Incentive Program, and to gather feedback from the States about the program. Every two weeks, CMS hosts an All-States Call that addresses a particular set of requirements or activities that the States must undertake to successfully participate in the incentive program.

Finally, it is also worth noting that States are engaged in a number of outreach activities to reach their providers directly. Many states are pre-determining eligibility for the program through data matches in their systems to target outreach directly at providers with high Medicaid patient volume and those working in FQHCs and RHCs. States are leveraging the communication tools and resources already in use (e.g. Twitter, websites, newsletters, town hall meetings, etc.) to conduct outreach for this program.

Beyond the Stage 1 Criteria for Meaningful Use

CMS plans to build on our experience and achievements to meet our policy goals for EHR implementation. CMS intends to pursue future rulemaking that would outline two additional stages of criteria for meaningful use. In planning for future stages of meaningful use, CMS is seeking input from a variety of sources, including the Health Information Technology Policy Committee, State Medicaid agencies, and provider feedback from the Stage 1 implementation. CMS will carefully evaluate this input as we work towards our goal of meeting our policy priorities and supporting the health care community's ability to meaningfully use certified EHR technology through flexible and feasible regulations. The Stage 2 proposed rule is expected to be released in early 2012.

Looking Ahead

I am happy to present CMS' progress and accomplishments in implementing the EHR Incentive Programs at such an exciting time for developing and implementing the programs. Just one year ago, we were still working with professionals, including small and solo providers, hospitals, and other stakeholders, to define what it means to meaningfully use EHRs and how we can measure

that without undue provider burden. Now, we have thousands of professionals and hospitals registered to participate in the EHR programs, reporting their use, and receiving payments to help them continue to move toward a fully implemented EHR system. Together, we are advancing toward using EHRs to improve patient care and coordination while improving the efficiency of health care.

CMS plans to continue to reach out and inform eligible professionals and hospitals about the benefits of participating in this program. CMS will continue to participate in calls, webinars, and conferences explaining how eligible professionals and hospitals can receive incentive payments. CMS will also publish articles and disseminate information about the EHR Incentive Programs, so that as many professionals and hospitals as possible are aware of the program and the resources available to help them make the switch from paper to electronic records. Over the last 30 years, we have watched information technology transform industry after industry, dramatically improving the customer experience and driving down costs. Now that government and stakeholders are coming together, we are finally poised to make the same transformation in health care.

U.S. House of Representatives Small Business Committee
Health and Technology Subcommittee
Rayburn House Office Building 2360
Thursday, June 2, 2011

Testimony
Sasha Kramer, M.D., FAAD

Good morning Madame Chairwoman and distinguished members of the committee, especially Congresswoman Herrera-Beutler who represents my hometown of Olympia, Washington. My name is Sasha Kramer; I am a board-certified dermatologist and I appreciate the opportunity to speak to you today about health information technology (HIT) and the challenges facing physicians surrounding the selection, purchase and implementation of electronic health record (EHR) systems in their practices.

I am a solo practitioner in Olympia where we only have four full-time dermatologists, and one who works part-time, serving the metro area population and beyond, including Lewis and Pacific counties, which have limited access to practicing dermatologists. In addition, I volunteer for the Thurston County Project Access, which provides health services to the uninsured and underinsured populations in Thurston County, Washington. I opened my practice two years ago after four years of working within a larger group practice. I currently employ two and a half employees, see an average of 100-125 patients per week and generate 40-45 percent of my revenue from Medicare and Medicaid patients.

Over two years ago, I purchased an EHR system at a total cost of $41,349. I received $19,964 through a grant funded by the Washington Health Information Collaborative for Health Information Technology. Using business cash reserves, I paid for the remaining amount, totaling $25,385. As a solo practitioner, I was exclusively responsible for the research, selection, and ultimate implementation process of the EHR vendor and system. I spent over eighty hours selecting the vendor that best fit my practice needs. Once my EHR vendor was selected, an additional eighty hours was dedicated to training. During system implementation, my patient volume was dramatically reduced in order to integrate the EHR system into my practice. Initially, I saw one patient per hour so that the office staff and I could learn how to use the new system. It took about four weeks before I was able to return to my normal routine of 4 to 6 patients per hour.

To this point, it may appear that I have a relatively successful story to tell. However, just two years later, I am forced to re-invest in a completely new HIT system. One and a half years after I implemented my original system, I was notified by my software vendor that it had been acquired by another company and that the new vendor's products would not support my current network platform. The new vendor offered a different product, but because of the significant cost and concerns about the company's stability, I am looking at alternative vendors. Currently, I am looking at a new system that will cost in excess of $27,000 with $6,000 in annual charges; all of which must come out of my business cash reserves. It's not just the financial investment; I will again have to take time away from my patients to implement and train my entire practice on this new system. Currently, I am booked for the next five months for new patients; implementing a

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new system will again involve decreasing the number of patients that I can see for several weeks, further straining dermatology access in Thurston County.

Despite these factors, I fully support the infusion of health information technology into physician practices; it is a critical component in improving the health care delivery system and, more importantly, providing optimal patient safety and care. HIT serves as a foundation for efforts to reform the health care delivery system including integrated care models, quality measurement and analysis, payment reform, and improve technology to document and coordinate patient care. My practice and patients benefit from HIT in a number of ways, including the following:

- **Patient Safety and Care** – I have each patient's chart and information with me for each encounter and can accurately and carefully track drug interactions and medication refills and past medical history.
- **Practice Efficiency** – It is much easier to communicate with other providers and I am able to operate more efficiently with less employee time spent pulling and organizing charts.
- **Revenue Stream** – At the conclusion of each visit, my staff is able to send charges to the clearinghouse immediately for processing of claims and payments are quickly applied to accounts using electronic remittance.

Significant Barriers Prevent Optimal HIT Implementation

HIT holds promise as a tool to increase quality and efficiency in the health system. However, there are significant barriers to full-scale adoption and implementation of HIT – specifically, cost, regulatory barriers, financial penalties, an unpredictable marketplace and system integration. It is imperative that Congress ensure small physician practices are able to make the investment in technology that will enable the American healthcare delivery system to coordinate care and make a measurable impact on quality without imposing overly burdensome procedures or failed financial investments upon physician practices.

Financial and Regulatory Burdens

Dermatologists and other physicians in small practices face unique barriers to integrating EHR systems into our small businesses. According to the American Academy of Dermatology Association's (AADA) 2009 practice profile survey, 40% of dermatologists deliver care as solo practitioners; though solo practitioners make up 50% of rural practices. If efforts to modernize the practice of medicine are to succeed, we must figure out a way to assist physicians, particularly those in small practices, to overcome the significant financial barriers.[1] According to the American Medical Association, the average cost of an EHR system is estimated to be $30,000 per physician with an average maintenance cost between $3,000 and $15,000 per year. In addition, practices are also not convinced that operating costs will decrease with EHRs as 38% of practices responding to the 2011 Medical Group Management Association (MGMA) EHR Survey noted that their practice operating costs increased after implementation and 36% stated that they stayed the same.[2]

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[1] According to American Academy of Dermatology Association's (AADA) 2009 practice profile survey, 28% of dermatologists reported that they have implemented an EHR system.

[2] Medical Group Management Association, *Electronic Health Records: Status, Needs and Lessons – 2011 Report Based on 2010 Data Snapshot of an Infrastructure under Construction.* (http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=1248574.)

The financial cost is exacerbated by two factors – an unpredictable marketplace and access to capital. In a rapidly changing marketplace, which has already required me to purchase a second EHR system within two years, the inability to anticipate technology changes and the lack of system interoperability places a significant burden on my practice and my ability to care for patients. This unpredictable marketplace has certainly impacted my practice as I will invest more than $53,000 – it would have been $73,000 if not for the state grant – in two systems over the last three years. In addition, physicians seeking investment capital are having issues finding a lender willing to provide them with an unsecured loan. Others may attempt to finance their HIT system purchase with the vendor, but solo or small practices have little or no leverage in negotiating terms and rates because of our limited market share. [3]

Congress took an important step under the American Recovery and Reinvestment Act (ARRA) of 2009, when it authorized $20 billion in funding the EHR incentive program, but it is not enough.[4] The program should help stimulate interest in the adoption of EHRs by eligible physicians and hospitals through payments of up to $44,000 over five years under Medicare, or up to $63,750 over six years under Medicaid. Providers will need to meet several requirements to be eligible for the incentive funds including using a certified EHR system and become *meaningful users*, the regulations for which are currently flawed and unmanageable for many specialists. For example, one potential requirement would recommend that 10% of patients/families view and download their longitudinal health information, which would have to be made available within 24 hours of the patient's visit to meet Stage 2 meaningful use criteria.[5] The physician does not have control over the patient's ability, nor their desire, to view and download their longitudinal health information. In addition, a 24 hour requirement for making the information available to patients is a burden that affects a physician's workflow.

Dermatologists and other providers investing in EHRs are struggling with the structure of the CMS Meaningful Use timeline. The current schedule calls for the administrative rule governing Phase 2 Meaningful Use to be released in mid-2012. For early adopters who purchase a system and have contracts with technology service providers to meet 2011 and 2012 requirements (Phase 1), there will be a very short window between the release of Phase 2 requirements and the deadline for physicians' vendors to fully update their systems in order to qualify for the incentive payment in 2013.[6] This short timeline could cause early adopters of EHRs to fall short of Meaningful Use requirements based on the inability of their vendor to provide the required updates in the time allowed. In this instance, the ability of a provider to meet Meaningful Use criteria is completely dependent on whether the vendor is capable of implementing these changes in a timely manner. As dermatologists and other physicians make the decision to invest in an EHR, Congress and the Centers for Medicare and Medicaid Services (CMS) must ensure that early adopters are held harmless and not penalized based on their vendor's ability to meet the deadline.

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[3] Ibid. The 2011 MGMA EHR Study found that 72% of practices believe that insufficient capital resources are a significant barrier to EHR adoption.

[4] Ibid. The 2011 MGMA EHR Survey estimated that the full $44,000 in stimulus funds available to physicians would only cover the median up-front cost and up to two years of the operating cost of an EHR system.

[5] The Office of the National Coordinator for Health Information Technology Meaningful Use Workgroup Meeting Materials May 26, 2011: *Meaningful Use Stage 2 Objectives.* (http://healthit.hhs.gov/portal/server.pt?open=512&objID=1472&&PageID=17094&mode=2&in_hi_userid=11673&cached=true).

[6] The Office of the National Coordinator for Health Information Technology Policy Committee Meeting Materials May 11, 2011: *Meaningful Use Presentation.* (http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__policy_past_meetings/1814).

Furthermore, quality measure reporting to achieve meaningful use is one of several burdensome reporting requirements physicians are facing through Medicare. The Physician Quality Reporting System, e-prescribing, and looming development of ACOs all require reporting of various disparate quality metrics. Simply understanding and implementing all of these different programs is extremely difficult, and often overwhelming, as a small practice.

Despite demonstrated financial and regulatory burdens, physicians face financial penalties starting in 2015. Dermatologists and other physicians who do not adopt certified EHR systems, meet the definition of "meaningful user," use e-prescribing and/or participate in the PQRS face phased-in penalties that reduce overall Medicare payments.

System Integration and Workforce Issues

Moreover, there remains a large question as to whether we can build an interoperable, national infrastructure, long a barrier to HIT adoption. Right now, we appear to be running the trains, but the tracks are not yet built.

To deliver on the promise of effective care coordination and improvement in quality of care, a fully functional health information exchange is a prerequisite to enable all physicians to maximize use of health information technologies. Dermatology is fortunate that it was able to recently develop specialty-specific criteria while many other specialties do not yet have specialty-specific HIT certification programs. This prevents the ability to build a seamless HIT network for patient care and leaves a sizeable group of physicians without the ability to take advantage of the stimulus funds to offset the cost. Physicians are hesitant to invest in systems that may not be up to par with the standards for a nationwide health information exchange. If you add in anecdotal evidence such as my practice having to invest in two different systems within three years, physicians are rightly justified in their hesitancy.

Those dermatology practices shifting from paper to electronic records or transitioning from one vendor's platform to another will have to address several critical issues; (1) large patient loads which require fast turn around and minimal disruption during the record transfer, (2) the cost of data conversion from one system to another, (3) the potential for creating even longer waiting periods for patient appointments, the average wait for dermatologic care being 5-6 months in my community, and (4) the need for specialized software to accommodate the practice of dermatology (such as the ability to draw and upload photos).

Most importantly, patient care could be at risk if we are unable to provide the necessary resources and protections to physicians for HIT adoption. I am concerned that we could exacerbate the physician workforce shortage facing the country, not just in primary care, but across specialties. Beyond the capital investment, physicians, particularly solo practitioners, will face significant financial penalties for failure to comply with e-prescribing, HIT, and potentially PQRS requirements. The AADA fears that those dermatologists and other physicians nearing retirement would simply retire earlier rather than comply with the new regulations.

I urge the committee to address three issues:

1. Provide sufficient financial and other resources so physicians are able to select and implement HIT systems.
2. Consider delaying the penalties associated with HIT adoption until such time that a functional integrated system is in place. At the very least, consider grandfathering

physicians of a certain age and exempt them from financial penalties so we do not push some into retirement and exacerbate the physician shortage in this country.

3. If penalties are not significantly delayed, provide a "safe harbor" for those early adopters of HIT to protect them from financial penalties related to the "meaningful user" requirement. They should not be punished for the failures of their EHR vendor to implement new criteria--- something completely out of their control.

It is imperative that HIT is adopted and implemented in a timely manner that is achievable for dermatologists and all physicians. We need to develop an interoperable and secure health information exchange network that is user friendly and protects patients' privacy.

The challenges facing the overall Medicare program are complicated and carry significant fiscal implications as well as the potential for unintended consequences on access to care. We must work as partners and as responsible stewards of the nation's health care resources. We must strike the right balance between modernizing the practice of medicine, delivering high quality care and protecting patient care. I, and the American Academy of Dermatology Association, look forward to working with you in hopes of achieving this balance.

Thank you for the opportunity to testify before the subcommittee today.

Testimony of Denise Lea Elliott, DPM

Member, American Podiatric Medical Association
Solo Practitioner – Marrero, Louisiana

Before the Subcommittee on Healthcare and Technology,
House Small Business Committee

"Not What the Doctor Ordered: Health IT Barriers for Small Medical Practices"

June 2, 2011

Chairwoman Ellmers, Ranking Member Richmond, and Members of the Subcommittee, I welcome the opportunity to testify before you today on behalf of myself and the American Podiatric Medical Association (APMA). I commend this Subcommittee for its focus on the vital issue of how the implementation of health information technology and electronic health records under the Medicare program will impact small medical practices.

I am Dr. Denise Elliott, a member of the APMA and a practicing doctor of podiatric medicine in solo practice in Marrero, Louisiana. APMA is the premier professional organization representing America's Doctors of Podiatric Medicine, or "podiatrists." Podiatrists provide the majority of foot care services to the Medicare population. APMA's mission is to advocate for the profession of podiatric medicine and surgery for the benefit of its members and the patients they serve.

Madame Chairwoman, more than 65 percent of the podiatrists in this country practice in one or two person groups, and thus fall well within the definition of a small business. These podiatrists and practices, usually employing a very small support staff and enjoying modest annual revenues, face the same challenges confronted by all small businesses that must compete in marketplaces that do not always provide a level playing field. I have observed that many of the policy issues faced by the podiatric medical profession are, fundamentally, small business issues that in many cases apply to other small medical practices as well. Podiatry practices and other small businesses can and do compete successfully against large businesses when the terms of that

competition are fair. But success becomes difficult when the same demands are made upon large and small businesses with no consideration of the unique pressures placed on the small business.

Congress is to be commended for recognizing the potential value of health information technology, and how the implementation of electronic health records has the potential to improve patient care and produce efficiencies that reduce costs. Chronic diseases such as diabetes, heart disease, and kidney failure have devastating effects on patients. The treatment of these chronic conditions utilizes a tremendous amount of health care resources. Many of these ailments have significant effects on the lower extremities, and the feet in particular. Utilizing electronic health records to coordinate care has the potential to eliminate unnecessary duplication of diagnostic tests. Giving doctors the ability to access information on the patients they care for in real time has the potential to significantly improve the treatment, and the lives, of patients. At the same time, such communication and coordination should save the cost of duplicative tests, reduce emergency care and hospitalization admissions, and decrease the practice of defensive medicine. The APMA fully supports this initiative that will help doctors of podiatric medicine provide better care for the patients they serve.

Undue Financial Burden

However, requiring eligible providers to implement electronic health records for Medicare in a "meaningful way" over the next five years places an undue financial burden on the majority of podiatrists that are small business owners. And while there is certainly an incentive program to encourage practitioners such as myself to adopt an EMR system that is comprehensive and inter-operable, it in no way begins to take into account the great expense that a solo or two-physician practice will incur. Economies of scale work in favor of larger podiatric or multi-specialty practices, and I know that some hospitals have cost-sharing programs with doctors on staff. However, that is not true in my case.

In my practice in Marrero, Louisiana I have not yet implemented an electronic health record system, although I have explored and continue to explore the possibilities. In addition to the cost, I fear the effect it may have on my practice in terms of the disruption of care that I can provide to my patients during the procurement of hardware and software, converting patient

records, learning and implementing the system as a practitioner, and training staff. And while I certainly understand that an EMR system would benefit patients, will it require more – or less – physician and staff time, and will it ultimately be beneficial to my practice? The worst thing that could happen would be to lose my practice because of the costs – both known and unknown – of implementing an EMR system.

Daunting Task

It is a daunting task to figure out where to start with almost 500 certified programs listed on the ONC-HIT Product List. I am affiliated with the West Jefferson Medical Center in Marrero, and have a practice location in the hospital's complex. I decided to initially look at a product that is utilized by the hospital. It seemed logical to me to put a system in my offices that would work seamlessly with my hospital system, and would potentially simplify my efforts in establishing electronic health records in my practice.

As I investigated the system, I was astounded at the costs. An upfront fee of $5,000 per doctor (while currently a solo practitioner, I have had associate doctors work for me in the past and potentially could have an associate in the future), an installation fee of $2,000 per office, and then a monthly maintenance fee totaling $7,200 annually per doctor. This program has a lease purchase option, but those costs are only related to the actual electronic health record software.

The cost for additional hardware—computers and servers that I would have to purchase—was not included and could run an additional $15,000 to $20,000. Also, I would need to purchase a digitized x-ray system at an additional significant cost to be truly EMR compliant – all of this at a time when Medicare is decreasing reimbursements for radiology services and physicians.

Because of my concerns, I sought direction and advice from podiatric colleagues across the country who had implemented or attempted to implement this particular EMR program. I found that they were not pleased with the product and several had discontinued their relationship with the company. I am now evaluating other EMR options, but am consistently finding the software installation and training costs to be between $25,000-$30,000 per system, with additional per doctor monthly fees of $300-$600.

Medicare Incentive Helpful but Insufficient

The current Medicare incentive program offers $18,000 this year or next year if I implement an EMR program and demonstrate meaningful use for 90 consecutive days, which requires meeting a complex set of conditions in charting the care of my patients in the certified program. Once I attest to meeting the conditions, I am told I will receive the incentive payment within four to eight weeks. After initial success reporting meaningful use for 90 consecutive days, I will be required in subsequent years to demonstrate meaningful use for an entire year, and then submit my information to qualify for my incentive payment. In theory, if I am able to purchase a certified EMR program this year and am able to successfully implement it into my practice and meet the requirements for the initial incentive payment, I will get the $18,000 this year. As you can see from the costs I have outlined, this will help with a portion of the costs for the software, but the investment to upgrade my current computers – or purchase new computers that can run the software – will be entirely at my expense.

If I can then demonstrate meaningful use of EMR for the entire year in 2012, and if Medicare pays the incentive payments in a time frame similar to that which occurs with the e-prescribing and Physician Quality Reporting System (PQRS) bonuses, I can anticipate my next incentive payment of $12,000 sometime in the fall of 2013. For the intervening time between incentive payments, the financial burden will fall on me as a small business owner.

Vendor Certification Concerns

The implementation of EMR in a meaningful way is a staged program. The initial Stage 1 level makes the least demands on how the electronic health record needs to be used in one's practice in order to qualify for the incentive. The program is set up to advance to Stage 2 requirements in 2013 and eventually to Stage 3 requirements for full implementation of electronic health records and maximum patient care. But EMR vendors are currently not certified beyond Stage 1. In fact, vendors have only temporary certification of their software programs.

The fear that I and many of my podiatric colleagues have is that as vendors are obligated to meet the demands of Stage 2 and Stage 3 requirements, they may not meet those requirements or retain certification. Also, we fear that vendors will incur increased costs to meet the

requirements and these costs will eventually be passed along to the end users—the doctors. I have seen this occur with electronic billing systems, and the upgrade costs that I had to pay when changes were made to electronic claim submissions were significant. There is no provision in the current law to limit these potential charges or to provide additional incentive payments to help the eligible provider offset these costs.

Initial Negative Impact

I have addressed the financial impact that implementing an electronic health record system will have on me as a small business owner, but that is just one of the many effects it will have on my practice of podiatric medicine. Implementing electronic health records in my practice should ultimately help me provide better care to my patients, but initially it will have a negative impact on my practice.

Unquestionably, as I begin to use an EMR system, I will not be able to treat as many patients on a daily basis. Adjustments will have to be made to office workflow, and demands on my time and the time of my small support staff are likely to increase. Typical EMR implementation takes anywhere from six to eight months, and I anticipate that I will not be able to treat the same patient load during that period. This could potentially impact my patients' health as well as my practice's bottom line. There will be a dual impact on the care that my patients can receive, and on my practice, which is likely to suffer from a reduced patient load.

Interoperability Concerns

Ideally, health information technology should improve the communication between health care providers, hospitals and medical diagnostic services. The process should allow health care providers to access all the medical information contained in the patient's electronic health record and use that information to provide the optimal care for the patient.

I am concerned that, with nearly 500 certified EMR products on the provider side and a significant number of other products available for hospitals, these different products may not actually communicate effectively.

Ideally, the vision put forth is that all the providers and facilities would communicate their information to a Health Information Exchange (HIE). However, the infrastructure for these

has not yet been developed. How am I to know that the EMR program that I select will be able to eventually communicate with a HIE? Furthermore, what accommodations will my vendor have to make to meet the compatibility requirements, and at what cost to the vendor and eventually to me? There are so many unknowns it is sometimes paralyzing.

Concerns about Meaningful Use Criteria

Finally, it is clear that the components of qualifying for meaningful use are focused on services provided by primary care providers. While as a podiatrist and eligible provider I can qualify for Stage 1 Meaningful Use, it is more burdensome moving forward to Stage 2 and Stage 3. This is true for all specialty health care providers, not just for podiatrists. It would be helpful, as the program moves forward, for CMS to work with specialty providers to adapt the meaningful use requirements to the quality elements that are directly related to the important care that specialists provide for patients with chronic disease conditions.

With regards to podiatry, it has been demonstrated in numerous studies that the foot care provided by podiatrists to persons with diabetes significantly reduces ulcerations, hospitalizations and ultimately amputations. This results in a marked improvement in the health of the persons with diabetes, and significantly decreases health care costs. Issues such as these need to be addressed in the quality measures implemented in electronic health records.

Small/Solo Practitioners Need More Assistance

As I have outlined, the financial impact on me as a small business owner in complying with the requirements of health information technology and electronic health records is overwhelming and could be disastrous. The Medicare incentive program is a per doctor program. Therefore large practices enjoy a significant advantage in the economies of scale that are present in integrating electronic health records, and have the administrative staff to assist in the process. This is not the case for me and the majority of practicing podiatrists across the country – or for the majority of small physician practices of any type.

One possible solution is for Congress to establish additional incentives for small business owners who successfully implement electronic health records, and set up additional implementation support for those providers.

Conclusion

Madame Chairwoman and Members of the Subcommittee, I again thank you for providing me with the opportunity to speak today on behalf of the APMA and podiatric physicians regarding the challenges presented by the implementation of health information technology and electronic health records into solo and small medical practices.

I will be happy to answer any questions you may have.

Statement of Andy Slavitt, Chief Executive Officer
OptumInsight (which was formerly known as Ingenix)

To the Subcommittee on Healthcare and Technology
Committee on Small Business

June 2, 2011

Introduction

Madam Chair, Ranking Member Richmond, thank you for the opportunity to testify today on the barriers faced by small group practices and single physician professionals in adopting and implementing health information technology.

My name is Andy Slavitt and I am the CEO of OptumInsight, which until recently was known as Ingenix. Let me open with a word on this very relevant topic. It is well-understood that America's future is very much intertwined with making our health care system more productive. Physicians make the vast majority of decisions that impact cost and quality of care, and we believe technology could be vital in supporting their ability to do so effectively.

Physicians who practice in small practices, who once were the cornerstone of health care in most communities, are already an endangered species. In the 10 years prior to 2007, the percentage of visits to physicians who were solo practitioners decreased 21 percent. The trend has only grown more severe since.

Scale requirements are increasing, complexity is increasing, payment models, by necessity, are changing, and administrative costs to manage a practice are increasing, crowding out the ability of the independent physician to focus on patient care. Nationwide, the American Academy of Family Physicians has estimated we will have a shortfall of 40,000 primary care doctors by 2020. As a result, we will lose many of our chances to catch preventable, treatable health conditions early in their development when the risks and costs are lower.

As the Office of National Coordinator has recognized and as the Federal stimulus payments in the HITECH Act are intended to support, technology can be part of the solution. This is an undertaking we support. Yet I believe this Committee and the Office of the National Coordinator for Health IT (ONC) are looking for a more practical analysis of how technology is being used and can play a role in supporting better cost and quality outcomes. The answer is decidedly mixed. And, until this is addressed, adoption will lag.

There is an obvious contrast at work. In a world where cloud computing, mobile technology and social networking are democratizing low-cost access to a variety of sophisticated capabilities for individuals and small businesses, if asked, the typical physician may tell you that the technology in their office or hospital has often become a contributor to the challenges they face. This is because from a physicians' point of view, technology isn't always a tool, as we're used to thinking of it, but rather the source for another set of compliance requirements, fixed costs, and productivity reducers. Net-net, technology as it is typically fashioned today creates additional burdens which contribute to the wave of issues scaring doctors into salaried jobs in hospitals, which exacerbates the primary care shortage that exists in critical communities in this country. It doesn't need to be this way. There's the potential for a silver lining coming from the cloud.

OptumInsight

With 14,000 employees worldwide, OptumInsight is one of the largest health information technology services companies in the world. Where better information is needed to improve how the health care communities we all live in function, it is our mission to help provide it. We have more than 200 decision-support software products; have created and maintain the leading methodology for measuring cost and quality of episodes of care; are a leading provider of information exchanges and of technology to support care delivery in Emergency Departments and Intensive Care Units.

What gives us perspective on this topic is the pioneering work we have done with small physician offices and their use of technology. In concert with the American Medical Association we have created model physician offices to springboard practices that have no technology to completely modernize. We have created a low-cost cloud-based electronic health record (EHR) and practice management application known as Ingenix Caretracker available through devices such as iPads to help physicians manage their practice and their patients in the most seamless manner. And we were honored to be one of the very first health IT companies in the nation to have physicians, including Dr. Douglas Foreman in Warwick, Rhode Island achieve Meaningful Use. Because we also provide connectivity to more than 65 different EHR systems that allow physicians to exchange clinical data in their communities and have assisted in the implementation of nearly every type of EHR technology in the market, we have learned what works. Help doctors make the complex simple and you will see improvements in productivity and adoption; resist the urge to support efforts – even tied to financial incentives – that do otherwise by adding complexity.

The Opportunity of Technology: Simplification

The fundamental promise of technology is to improve productivity by unlocking human potential. This is true at the policy level, where technology can support the delivery of high quality care more consistently at the lowest cost. And at the patient level, where physicians can spend more time with the patients who need it most, managing their conditions in the right settings, with the best information, while minimizing the administrative time spent managing a practice.

As a practical illustration, I will walk through an example of what is at stake in a day in the life of a primary care physician and the impact of technology on a major productivity driver – reducing unnecessary hospitalizations.

Unnecessary hospital stays are costly to patients and the health system as a whole, resulting in an estimated $30 billion in annual waste. For patients to be released from the hospital with minimal risk for readmission, studies show that physicians need to actively manage the care of their patients before, during, and, in particular, after their release from a hospital. Yet, we estimate that primary care physicians are only aware about half of the time that their patients are even in the hospital. Doctors who are responsible for discharging patients tell us that they often will not release a patient from a hospital even

when they are likely ready to go home if their primary care physician has not been made aware of, or scheduled a follow up appointment. Without technology, this connection often does not happen.

The doctor, often a solo practitioner, is frequently too busy bouncing from patient to patient and in many instances, meaningful events, such as a patient entering the hospital, are not made apparent to them. Their day may be filled with 40 or more patient appointments, each of which may get no more than 10-15 minutes of their attention. To say nothing of the patient awaiting release from a hospital, data suggests there are a handful of patients who doctors and care teams see each day who drive the majority of the costs. They are typically Medicare or Medicaid patients with significant chronic conditions and a higher likelihood of hospitalizations. If these patients could be identified easily, physician offices could focus more attention on them and less on runny noses and other routine care requests. The only problem is without technology every patient looks alike until the doctor walks into the exam room.

In the exam room, a physician may give three to five different orders for each patient seen in a given day – prescriptions, lab orders, dietary restrictions, instructions on improving health status. At the end of the day, day in and day out, the doctor has given hundreds of orders – usually without any ability to track whether an order has been followed, or to reinforce with follow up calls, reminders or other support. Any missed order increases the chance that one of the patients of this physician will end up in the hospital. Without technology, loops open but never close.

The ability to track a patient, use data to prioritize and predict who is most likely to get sick, and to open and close the activities in an office are simple tasks for technology to support. And each is key to reducing unnecessary hospitalizations and other costs. Further, it requires less information technology than is used by an airline to manage reservations.

In communities where this sort of technology adoption is occurring, there is early evidence that unnecessary hospitalizations may be reduced dramatically. If technology is focused on simplifying these activities which add productive time to a physician's day, and physicians are given incentives to achieve these types of outcomes, there is real potential to save the federal and state governments tens of billions of dollars annually, improve health quality, and strengthen the ability of the independent or small group physician to operate in a connected but independent environment.

The Barriers: Complexity of Implementation, Cost and Uncertainty

The promise of technology to improve productivity only works if it unlocks the potential for the physician to improve how she works and the decisions she makes. Where that partnership between technology and human capability is missing, numerous barriers to adopting technology persist. If technology is viewed as adding complexity and compliance requirements, we should not expect a different outcome.

To be certain, physicians are not averse to technology itself. The nature of their work means physicians are hungry for new and better tools and procedures to help them deliver better outcomes for their patients. Among professionals, they are among the most prolific users of mobile devices, including iPads and other devices that simplify and improve their lives. Software companies like Intuit have found small physician offices are one of the most prolific users of small business accounting software, with approximately 75,000 physicians using the company's financial software products.

More financial incentives are not the issue. Incentives from the HITECH Act are improving adoption. The Centers for Disease Control conducted a survey and found that 41 percent of office-based physicians are currently planning to achieve Meaningful Use of EHRs and apply for incentive payments. Four-fifths of these, or about a third of all office-based physicians (32.4 percent), plan to apply this year. But one-third to 40 percent means a lot of work remains to be done.

So what is it about this technology that is creating barriers? Physicians will point to several barriers to adoption including costs, legal uncertainty, privacy regulations, and additional regulatory requirements regarding the use of technology. But the greatest barrier is that the decision support and productivity-enhancing capabilities that allow technology to solve simple problems such as connectivity, prioritization and workflow improvement are not driving the purchase and design of technology. They have taken a back burner to all of the compliance reporting requirements needed to demonstrate Meaningful Use and qualify for HITECH Act incentive payments.

As long as EHRs are designed principally around a set of needs in Washington and at the Centers for Medicare and Medicaid Services (CMS), it is a long-shot that the technology will provide the simplicity and productivity benefits at the heart of driving real adoption. Whether Meaningful Use standards are right or wrong is not the real issue. What is important is that today, the end-users, doctors and patients, are further away than ever from system design, because new product development is focused on satisfying those regulatory hurdles, rather than on simple innovations that improve productivity. As a result, program requirements are disruptive to the processes in place in increasingly busy offices.

Because of their size, and their focus on patient care, physicians in small practices lack many of the support structures larger businesses and health care organizations have to procure, implement and maintain technology. Further, the deck is stacked against them in terms of limited access to capital and the risk they must assume when making decisions to purchase technology that fundamentally changes the way they take care of patients and manage their practices. All of this spells complexity and if complexity requires the hiring of even one additional FTE to manage it, the temporary financial incentives will not be enough to compensate for productivity losses.

In this context, it is no wonder many physicians view the HITECH Act's Meaningful Use requirements with skepticism. Too often we hear from providers of care that the Meaningful Use and other compliance program requirements add to their daily burdens,

while seldom delivering distinct value back to them. Combined with poor alignment across federal programs – from quality reporting requirements (PQRS) to new program rules for Accountable Care Organizations – this environment makes adoption and use of health IT a compliance exercise rather than a solution.

Private industry is making strides at better understanding the day-to-day needs of physicians. We believe that technology that requires upfront capital investment or requires ongoing maintenance; that is not responsive to even modest evolutions in how the technology is used; and that does not break down the silos between the doctor and the world around them will face adoption challenges.

Cloud computing clearly provides the platform to solve some of these issues. OptumInsight's physician office technology has no upfront costs or maintenance required, it provides instant productivity improvement by automating processes for billing and collecting from health plans, and most importantly it is instantly updatable based on the needs of the user right through the cloud. We draw on expert practicing physicians who are part of our Independent Physician Advisory Board to provide the voice of end-users to our business operations and to guide development of solutions to ensure they deliver information, services and technology that truly assists providers in their practices. We have worked with thousands of physicians to implement health IT and to help them overcome their greatest concerns around uncertainty, cost, and complexity.

The HITECH Act created important momentum for private sector innovation to modernize the health ecosystem. Yet, there are common sense things that policy makers, both in Congress and the Administration, working closely with physicians and the private sector, can do to help overcome the barriers that continue to exist.

Five Recommendations

Against this backdrop of great promise and very clear barriers, we recommend focusing on simplifying the legal and regulatory environment so the private sector can focus its innovation on the things it has proven it can do: lower the cost and improve productivity benefits.

1. Prevent practice disruption. Congress has a responsibility to conduct oversight on the standards used in the $27 billion Meaningful Use program. A key goal for ONC should be to promote standards that reduce workflow burdens for physicians by adopting standards that focus on functionality for EHRs and Health Information Exchanges (HIEs) that solve real problems for providers in their daily practices. To this end, we believe the Administration should simplify and align incentives for physicians across multiple programs. While each one might even be well-thought out in isolation, the combination of Meaningful Use, Sustainable Growth Rate (SGR), Accountable Care Organizations, PQRS, Medicare and Medicaid medical homes, and the hospital readmission program standards should all be aligned into single, clear metrics and standards that can be built into any software. Further, Congress should support efforts to create administrative

simplification which unify clinical and administrative data and money flows. Likewise, Congress should encourage ONC to aggressively pursue prioritizing the list of Meaningful Use requirements and identify high value, high return measures that have the best potential of reducing practice disruption while supporting the goals of the Triple Aim (cost, quality, patient engagement). We have provided ONC and HHS with our recommendations on improved standards and are happy to share those with the Subcommittee.

2. Continue federal investments in HIEs, which should be as essential to CMS as MMIS systems, which pay Medicaid claims and administer benefits. For small practice physicians, certainty that HIEs are financially stable increases confidence in the decision to invest in an EHR system. They know that without the connectivity offered by an HIE, an EHR will be like using Google without the Internet. You can search on it, but you had better already have the answer.

   A model for sustainable HIE would combine administrative claims data and clinical information, giving providers a comprehensive view of their patients' health and medical history and supporting their ability to make better decisions at the point of care. Further, bringing these rich information sources together will provide the framework for value-added analytics that can support efforts to improve community health, and a source for permanent funding of the HIE.

3. Reduce uncertainty over the legal environment. Some physicians may fear that technology will become a basis for legal discovery and potential lawsuits. A 2009 study presented to the FTC showed evidence that "hospitals are 33 percent less likely to adopt EHRs if there are state laws that facilitate the use of electronic records in court." For the individual physician this is a vexing concern that is part of the shift to salary and hospital-based physicians. Other physicians may welcome electronic records because, as another study suggests, the enhanced access to information record-keeping that EHRs offer may actually reduce the risk of medical error and the threat of lawsuits. Companies like OptumInsight are working to assure that EHR applications make important health care information, such as drug interactions, available and actionable in the physician's everyday work flow. We think it is also important to create an environment in which physicians who use EHRs are encouraged to improve patient safety and to report systems issues, without limiting patents' rights to legal recourse if they are in fact harmed by medical malpractice. We understand Congressman Marino and others are working on legislation to address these issues.

   Likewise, physicians may be slow to adopt EHRs if they have concerns about privacy and the use of patient data, as that data flows through HIEs, to other providers and across state lines. Clarifying the role of HIEs under HIPAA and providing for uniformity of privacy laws can help to address these concerns.

4. Provide small business benefits to small physician practices. Congress can help ease capital for investments in health IT and office modernization by passing

legislation to provide SBA loan guarantees for small and solo practices, and other clinicians not eligible for Meaningful Use incentives. In 2009, the House overwhelmingly passed such a program with bi-partisan support by a vote of 389 to 32. Unfortunately, the Senate did not act on the legislation. The bill would have provided a guarantee up to 90 percent of the loan for acquisition and installation of certified health IT. The loan amounts would have been limited to $350,000 to a single physician and up to $2 million for group practices. $10 billion would have been authorized, but because the program provides guarantees, would not have cost taxpayers any resources.

5. Shorten and improve the feedback structure. The perfect should not be the enemy of the good. We should not be afraid to abandon what is not working. Too often, government programs over-invest in systems due to bureaucratic inertia or incremental change versus transformation. When the system is flawed, such efforts do more harm than good. Conversely, the Regional Extension Centers (RECs), modeled after the 1914 Rural Extension Centers, are an example of what works well. The RECs are putting boots on the ground to assist providers learn about HIT adoption challenges, select tools that will best meet their needs and implement technology in ways to limit disruption. 62 RECs have received funding covering the entire country. The goal is to reach 100,000 priority primary care providers within 2 years. Cutting funding to the RECs would be shortsighted because it will limit adoption and inhibit efforts to use technology to reform delivery and payment systems that ultimately will save resources. Congress should continue to support the RECs.

Conclusion

For those that believe that the independent physician is a vital part of our health system and our communities, the promise of technology is essential to making that possible, particularly as a new generation of entrepreneurial and patient-focused physicians graduates from medical school. Creating an environment for success for these practices and private sector innovation should be the goal, while supporting and improving upon the effort that got underway in the HITECH Act. I applaud this Subcommittee for focusing attention on this issue and urge Congress to focus on providing assurance to physicians that this is a wise investment by promoting sensible regulatory and legislative structures that minimize uncertainty and foster simplicity.

Thank you for the opportunity to testify, and I am happy to answer any questions you may have.

OptumInsight Overview

OptumInsight, as a business, has been modernizing health care communities by helping them use data, analytics and technology to improve care, save lives and transform the way health care is delivered for 15 years. We are one of the largest health care information, technology, services, and consulting companies in the world. We have more than 14,000 employees worldwide and provide software and services to virtually all the major participants in the health care industry. We are known for the innovations that connect, inform and provide access to patients and their physicians, that help manage risk and reduce costs, that gather and analyze evidence of new treatments, and that help governments and policy makers keep health care safe and accessible while helping the system measure and improve its quality and cost performance. We believe information and transparency is at the heart of our ability to do this and are honored that we have become a small part in improving health care delivery for 6,000 hospitals, 240,000 physicians, 270 states and government agencies, 400 life sciences companies, and 2,000 health plan sponsors.

North Carolina State University is a land-grant university and a constituent institution of the University of North Carolina

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Address to the Healthcare and Technology Subcommittee

By David L. Baumer, Ph.D., J.D.,
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Re: Not What the Doctor Ordered: Health IT Barriers for Small Medical Practices

Date and Location: Thursday, June 2, 2011 at 10:00 A.M. in room 2360 of the Rayburn House Office Building

My name is David Baumer. It is a pleasure and an honor to address the Healthcare and Technology Subcommittee. Let me give you a little of my background and then address the issues that I was asked to discuss, which are "security and privacy concerns of health IT," and "possible liability issues associated with small practices."

For the past 5 years, I have been the Head of the Business Management Department, within the Poole College of Management, at North Carolina State University in Raleigh, North Carolina. My educational background is that I have a Ph.D. in Economics from the University of Virginia and a J.D. degree from University of Miami. I have been a member of the North Carolina State Bar Association for the past 31 years. My area of specialization is law and technology, which also makes use of my training in economics.

Much of my work is summarized by my vita and webpage, which can be accessed at: http://www.poole.ncsu.edu/index-exp.php/directory/dossier/david-baumer/. During the past 15 years at NCSU, I developed and taught a graduate course entitled, "Technology, Law and Internet."[1] In addition to analyzing the interface between IP and the Internet, the course dealt extensively with privacy and security issues, particularly online privacy and security. Referring to my vita, during the past few years I have looked at interventions of the Federal Trade Commission to preserve and promote reasonable consumer and user privacy and security [1, 5, 9, 15].[2] Among the issues that I have looked at along with colleagues from the Computer Science Dept. at NCSU (and colleagues from Virginia Tech, Georgia Tech and Carnegie Mellon) are the consequences of security breaches by firms that have been entrusted with personally identifying information (PII) [9, 15]. In my work with Professor Annie Anton at

[1] http://www4.ncsu.edu/~baumerdl/index.htm.
[2] The numbers referenced in brackets correspond to Part II. of my vita beginning on page 2.

NCSU, two firms we examined were an airline company (Jet Blue) and a credit bureau (ChoicePoint), both of whom were arguably negligent in their protection of PII and one was subject to substantial fines by the FTC.[3]

In 2004, along with two NC State colleagues, I wrote an article that was published by *Computers and Security* entitled, "Internet Privacy Law: A Comparison between the United States and European Union" [17]. In writing about privacy laws in the US relative to the EU, it became evident to me that protection of PII is much more comprehensive in the EU than in the US. More recently, in the Winter of 2011, along with colleagues from Virginia Tech and Georgia Tech, I coauthored an article entitled, "Privacy and Security in the Implementation of Health Information Technology (HER): US and EU Compared", published by the *Boston University Journal of Science and Technology Law* [2]. This article extensively reviews US and EU healthcare privacy law in light of recently enacted legislation, including HIPAA Privacy and Security Rules that have modified by the 2009 HITECH Act.[4]

Relying on prior studies, the points we make regarding EHR in the Boston University article are that:

(1) Adoption of EHR could result in huge savings in national healthcare expenses (possibly as much as 6% of the total of the $3 trillion spent on healthcare annually) [2],

(2) EHR will reduce medical errors, and

(3) EHR adoption result in improved quality of care.

Centralized and accessible healthcare records could bring about a National Health Information Network (NHIN) that will be one result of a public-private partnership that can be used to provide "'anytime, anywhere health care information and decision support...via a comprehensive knowledge-based network of interoperable systems."[5] According to a study by the Rand Corporation the adoption of health information technology (HIT) could save $77 billion annually from efficiency gains. However, it is important to note that much of these gains can only be achieved if all, or nearly all, of the healthcare organizations participate in sharing EHRs.[6] In other words, the economic efficiency benefits of using EHR are not linear, but rather accelerate for the entire healthcare system as the percentage of medical records in an electronic format approaches 100%.

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[3] ChoicePoint was fined a total of $15 million, $5 million to a consumer injury fund and $10 for unfair and deceptive trade practices. http://www.ftc.gov/opa/2006/01/choicepoint.shtm.

[4] Health Information Technology for Economic and Clinical Health (HITECH) Act, sec. 13402, Pub. L. No. 111-5, 123 Stat 115 (2009).

[5] Hiller, McMullen, Chumney, and Baumer [2]. Thanks to my mother-in-law who lives in Delray Beach, FL, also note voluntary efforts by organizations such as the South Florida Regional Extension Center (SFREC), which is a non-profit organization created last year to assist health-care providers, especially those with limited resources, staff and time as they convert to electronic medical records. Daniel Vasquez, SunSentinel.com, Monday, May 9, 2011.

[6] Network externalities are created when there is near universal use of a system. The importance of network externalities has been discussed and validated in a number of studies, S. J. Liebowitz & Stephen E. Margolis, "Network Externality: An Uncommon Tragedy, 8.2 of Journal Econ. Perspectives 133, 134 (Spring 1994) In healthcare the significance of network externalities has been discussed in John W. Hill et al., "Law, Information Technology, and Medical Errors: Toward A National Healthcare Information Network Approach to Improving Patient Care and Reducing Malpractice Costs," 2007 U. Ill. J.L. Tech. & Pol'y 159 (2007).

There is plenty evidence supporting the proposition that in addition to reducing healthcare costs directly, widespread adoption of EHR would reduce variability in the healthcare provided due to dissemination of best practices and more sophisticated use of healthcare data. Accessible healthcare data could provide more reliable analysis of hospital and physician performance outcomes, monitoring chronic diseases, monitoring medication adherence, promotion of safety metrics and a host of other secondary efficiency benefits [2, at 6]. The improvement in healthcare should be accompanied by a reduction in medical malpractice for the reasons state above, though this result is contested by other researchers.[7]

Huge efficiency gains in the delivery of healthcare as well as medical research, potentially achievable through near-universal adoption of EHR, are offset by possible increased risks to the privacy of individual medical records. Polls indicate that a majority of the U.S. public is skeptical of the ability of healthcare providers and organizations to ensure medical records will not be abused or facilitate medical identity theft (MIT) [2]. Among the abuses mentioned by survey respondents are providing unauthorized access to private medical data by marketing firms, employers, and insurers. In addition, survey respondents mentioned significant concerns about loss of control of their medical records and having to rely on the security practices of unknown firms to protect their sensitive medical information [2]. [8] Medical identity theft can be defined as the use of personally identifying medical information to gain access to health treatment or to file for reimbursements for false medical treatments, which could result in both diminished healthcare quality and financial losses, among other risks [2, at 7]. Regardless of the form of the abuse of medical records, having electronic, rather than paper, medical records enables identity thieves and fraudulent or unethical medical firms to potentially cause far more harm to patients. To state the obvious, once security is breached, thousands and even millions of records are available to skilled hackers.

In the EU, privacy laws are more comprehensive and deal with various scenarios, such as the right to compile personal information about citizens, the sensitive status of medical records, and document destruction policies [17]. In our recent Boston University article [2], we point out that EU medical privacy law is more wide-ranging than such privacy protection in the US and further, that use of EHR is much higher in the EU than in the US. It is certainly not clear that more comprehensive privacy laws led to greater adoption of EHR in EU countries, but there is some evidence that EU privacy laws have not deterred adoption of EHR.

Based on my work, all of which is coauthored with other leaders in the fields of online privacy and security issues, I can confidently make the following statements:

1. There are enormous potential efficiency gains in healthcare if electronic healthcare records become the norm,
2. The barriers to more widespread adoption are technical, economic, cultural, and legal,

[7] See article by Jean DerGurahian, http://searchhealthit.techtarget.com/healthitexchange/healthitpulse/liability-and-ehrs-how-electronic-information-changes-legal-landscape/.

[8] In [2] we note that, "HIPAA contains so many exceptions to when a patient's consent is needed to share information, that in practice is offers limited instances for patient choice;..."

3. Economic issues are addressed in the Patient Protection and Affordable Care Act by subsidizing healthcare firms that transform their records to an electronic format.[9]
4. There is substantial legal uncertainty as to the liabilities firms face if a mistake is made in the acquisition, storage, or transmission of medical PII.

I was asked to comment on 4., immediately above, but the technical, economic, and legal issues are inextricably intertwined. For example, a major technical issue that affects small firm adoption of EHR is interoperability and the consequences thereto. As stated above, the benefits of EHR take place when a patient's medical records can be accessed in a relatively short period of time and these records are complete or nearly complete. Quite obviously, for a small firm whose system may not be completely interoperable with other EHR systems, adoption of EHR can result in a double penalty: firstly that incur substantial startup costs in time and money to create an EHR infrastructure, secondly these are not receiving the benefits of information sharing.

According to anecdotal information that I have gathered and received, EHRs are increasingly being pooled, but accessing the pooled data is still problematic for some firms, particularly small healthcare providers. It was mentioned to me by doctors and some patients who talked physicians and other medical staff, that codes used by contributors to the pooled medical information were not standardized and therefore sharing of data and interoperability remains a goal, but is not reflective of current reality.

Let me close by making several points:

1. At least in the short run, widespread adoption of EHR will not reduce legal uncertainty. According to a recent article in the *New England Journal of Medicine*, "EHRs hold considerable promise for preventing harmful medical errors and associated malpractice claims, but on the other hand, despite experts' optimism, there is no evidence that that use of EHRs reduces diagnostic errors." In a Nov. 23, 2010 article by Jean DerGurahian, which cites the *New England Journal of Medicine* article, "The question is whether EHRs will help providers defend against such claims [malpractice and medical liability] or leave them more vulnerable—the answer seems to be, they will do both."

2. In an article [1] that I recently coauthored with Professor Travis Breaux of Carnegie Mellon, we explored what firms can do to avoid liability in the form of fines from the FTC [1]. We state that "Lawyers representing firms and other organizations, regulators, system administrators and engineers all face considerable challenge in determining what constitutes 'reasonable' security measures for several reasons, including:"

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[9] Pub.L. 111-148, 124 Stat. 119, to be codified as amended at scattered sections of the Internal Revenue Code and in 42 U.S.C..

A. Compliance (creation and use of reasonable security measures) changes with the emergence of new security vulnerabilities due to innovations in IT. In other words, it is not enough simply to invest in IT infrastructure, users must be alert to changes in IT that make existing security measures possibly superseded,
B. Compliance requires knowledge of specific security measures and current best practices. For example, note that Microsoft was prosecuted by the FTC in 2002 when it claimed that security for its Passport Wallet products [5, at 292] was improved relative to its existing products.[10] In the consent decree, the FTC required that Microsoft implement administrative, technical, and physical safeguards appropriate for the respondent's size and complexity, the nature and scope of respondent's activities, and the sensitivity of the personal information collected from or about consumers." In effect, the FTC claimed that Microsoft's current security was not "state of the art" and that the FTC had some definite ideas from improvement. No customers of Microsoft's Passport products were ever victimized by identity thieves or other abusers, such as spammers. Again, if Microsoft is subject to a suit based on its description of its security for its Passport Wallet products, it is no wonder that small healthcare firms are leery about adopting EHR and then describing the system to their patients and customers.

3. It is inevitable that even the most high-tech firms are going to be victims of hacking incidents. In the recent IT security break-ins involving Sony PlayStation Network, the CEO Howard Stringer said in a May 17, 2011, Wall Street Journal article that "...maintaining the service's security is a 'never-ending process' and [he] doesn't know if anyone is '100%' secure."[11] If Sony is unable to guarantee security to its customers, then surely doubts creep in to small healthcare providers who do not have near the IT expertise that Sony possesses.[12]

NC State Associate Professor in Business Management, Fay Cobb Payton, et al., recently wrote an article entitled, "Health Care IT: Process, People, Patients and Interdisciplinary Considerations," in which it was stated that, "Despite this great promise, the impact of IT on healthcare over the past decade has so far been modest. Currently, almost 80 percent of the physicians—the majority in small, independent practices—lack even rudimentary digital records. Where electronic records do exist, they are typically limited in functionality and poor in interoperability."[13] According to Professor Payton et al., "Compared to other industrialized nations, the United States lags far behind in the use of electronic health records and global economies can and have benefited from the implementation of information technology in

[10] Microsoft Corp., No c-4069, 2002 WL 31881313 (Fed. Trade Comm'n Dec. 20, 2002).
[11] Daisuke Wakabayashi, "Sony's Chief Warns on Security Risks," *Wall Street Journal*, May 17, 2011.
[12] Id., also see my interview with the Technician: http://www.technicianonline.com/news/professor-sony-playing-with-fire-1.2554264.
[13] Fay Cobb Payton, Guy Pare', Cynthia LeRouge, and Madhu Reddy, "Health Care IT: Process, People, Patients and Interdisciplinary Considerations," 12(2) Journal of Association for Information Systems I (February 2011).

the health care domain."[14] Also noted in the Payton et al., article [as well our Boston University article] EHR is patient privacy concerns, which hinder use of EHR for public health and research initiatives.[15]

It is my opinion that the adoption of EHR by small healthcare firms has been comparably slow and the true promise of EHRs has not been realized. However, I am limited to commenting about changes in the legal system that could reduce the barriers to more widespread adoption of EHR by small healthcare organizations. As stated above, the barriers to more prevalent use of EHR are combination of economic, technical, cultural, and legal factors.

My legal recommendations are, to the extent feasible, that:

- Small health care organizations should be provided with **safe harbors** in which they can acquire, store, and transmit medical records electronically without fear of lawsuits by either government agencies or class action suits by private citizens.
- Small healthcare organizations should not have to be IT specialists, aware of every nuance the constant battle between corporate IT security specialists and the malware hacking community. Small healthcare organizations should not be charged with knowledge of recent actions by the FTC to protect PII of patients and customers.
- Currently HIPAA does not contain a private right of action, nor should it.
- Identifying reasonable security measures to protect patient medical records stored electronically is an imposing task that time does not permit me to elucidate. A step in the right direction is ***software criteria*** developed by the Dept. of Health and Human Services so that software used by firms that store medical PII in electronically can be certified.[16] To date, ARRA certification would require periodic tests, whose frequency has not been determined. The bottom line is that small health care firms that used American Recovery and Reinvestment Act (ARRA) certified software ought to be insulated from suits by HHS, the FTC, and class action patient suits. I recommend creation of a **due diligence defense** that is linked to use of ARRA certified software and the FTC should not intervene and contend that the software used by a healthcare provider, though ARRA certified, is nevertheless inadequate.[17]

I am convinced that the main barriers to the adoption of EHR by small healthcare firms are due to legal and economic uncertainty. The basic principles of economics and network externalities suggest that pursuant to the Patient Protection and Affordable Care Act, government subsidies to small healthcare firms to promote adoption of EHR are economically justified, though the appropriate magnitude of the subsidies is difficult to estimate.[18] A key technical issue is easy interoperability (access and sharing of

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[14] Id., i.
[15] Id., i. and [2].
[16] American Recovery and Reinvestment Act,
[17] See work of Professor Annie Anton of the NCSU Computer Science Department and her Ph.D. students (Aaron Massey and Jeremy Maxwell) linking HIPAA and HITECH Privacy and Security rules with software code that is used by requirements engineers to comply with medical privacy and security laws.
[18] A discussion of network externalities takes place at: http://www.utdallas.edu/~liebowit/palgrave/network.html. Work by Professors Stan Liebowitz and Steve Margolis (at NCSU) suggest that when networks are created users

medical data) that is not plagued by unsynchronized, medical codes. Finally, legal uncertainty can scare away small healthcare providers whose main interests are healthcare not IT, but the potential benefits of ubiquitous adoption of EHR are enormous.

Once again, it has been a pleasure to address this important committee before the House of Representatives.

Sincerely,

David L. Baumer

David L. Baumer

derive two values from participation, (1) individual value, which is the value if there are no other users, and (2) synchronization value, the value of being able to interact with other users of the product.

Chairwoman Ellmers
Subcommittee on Healthcare and Technology
Questions for the Record
Karen Trudel
Department of Health and Human Services
"Not What the Doctor Ordered: Health IT Barriers for Small Medical Practices"
June 2, 2011

1. **Under the proposed rule filed May 26, 2011, CMS would permit some additional exemptions from the e-prescribing payment adjustment. However, I am concerned that physicians may not be aware that they must report e-prescribing activity this year to avoid penalties that begin next year. They may not have the financial resources to purchase health IT, and may also face reimbursement penalties, which they cannot afford. Do you think additional hardship exemptions are warranted for very small practices or those with limited financial resources?**

   Answer: The proposed rule does provide additional hardship exemption categories for the 2012 e-prescribing payment adjustments. We are accepting comments through July 25, 2011 on our proposed rule, and will carefully consider all of the comments that we receive before finalizing the regulation.

2. **Including the new proposed hardship exemptions, how many small practice physicians do you estimate will be eligible to file for hardship exemptions for the e-prescribing program by October 1, 2011?**

   Answer: Based on our analysis of 2010 Medicare Part B claims, we believe the number that would need to be a successful electronic prescriber or apply for a hardship exemption to avoid being subject to a penalty could be approximately 200,000 eligible professionals. It is hard to estimate, however, the number of small practices that would be eligible to request a hardship exemption and will apply for a hardship exemption.

3. **We have heard that there are many physicians who are not yet aware of the brief January-June 2011 e-prescribing reporting period for the 2012 Medicare payment adjustment. Will CMS consider extending the reporting deadline until December 31, 2011?**

   Answer: CMS understands that the scope of these programs is vast and that doctors and facilities across the country have varying awareness of EHRs and of the incentive programs. As a result, CMS is conducting wide-scale outreach efforts to educate those eligible for the program – hospitals and eligible professionals, as well as States, and provider stakeholders. Outreach for the Physician Quality Reporting System and the E-prescribing (eRx) incentive programs have been on-going. CMS has held monthly national provider calls and frequent open door forums to help get the message out. We

have been in contact with the American Medical Association and various specialty societies to assist us in educating physicians and other eligible professionals regarding the various reporting programs.

Revising reporting period for the 2012 eRx payment adjustment would first require additional notice and comment rulemaking. Further, as indicated in the CY 2011 Medicare Physician Fee Schedule final rule with comment period (75 FR 73562), creating a longer reporting period is not operationally feasible without making retroactive adjustments to payments. Consistent with section 1848(a)(5) of the Social Security Act, CMS selected a reporting period that precedes the year in which the payment adjustment applies in order to apply the payment adjustment concurrently with claims submitted for the payment year. However, CY 2011 PFS Final Rule also established a 12-month reporting period (between January 1, 2011 and December 31, 2011) for purposes of the 2013 payment adjustment.

Specifically, the process required to perform a full analysis of eligible professionals' claims data can take more than five months to complete. This is due to numerous factors, including the allowance of a one month run-out for claims processing (for example, through July 29, 2011, for claims with dates of service of January 1, 2011, through June 30, 2011). Additionally, the time required to perform the data analyses to determine non-successful electronic prescribers, and to update the systems to make the appropriate reductions to PFS payments for claims submitted on or after January 1, 2012, can take up to four months to complete. Taking into account these operational issues, for the 2012 eRx payment adjustment, we finalized a reporting period of January 1, 2011, through June 30, 2011.

4. **How do you believe small medical practices are tracking the numerous EHR and e-prescribing regulatory requirements and deadlines?**

Answer: CMS is conducting wide-scale outreach efforts to educate those eligible for the program about the program guidelines for incentive payments. Specifically, CMS has held focus groups around the country to gauge the unique challenges facing eligible professionals, including those practicing in small and solo practices. In order to make our outreach efforts accessible to a wide variety of providers - including those in small practices or rural settings - we focused our efforts on mechanisms that are free, flexible and widely accessible (such as web-based trainings or phone calls). In addition, we sought a balance in our meaningful use requirements to better accommodate eligible professionals, including those in small practices, by allowing them to defer some of the requirements that require interface and exchange with other entities. Our research has shown that awareness of the incentive programs has been growing steadily over the past year.

CMS has also released a wide variety of educational resources, including a detailed overview timeline for eligible professionals to assist them in planning and implementing the EHR Incentive Program, FAQs that detail the requirements and timelines of the

various programs, User Guides that provide step-by-step explanations for registering and attesting for the EHR Incentive Programs, and Meaningful Use Specification Sheets that provide a comprehensive overview for each of the meaningful use objectives. Further, CMS holds regular Open Door Forums via telephone that provide eligible professionals with an opportunity to not only gain an overview of the EHR Incentive Programs, but also to ask questions and get answers directly from CMS experts. In addition, CMS is currently planning a number of educational resources that we will be of particular assistance to small practices, including a "Beginner's Guide to Meaningful Use."

Eligible professionals also have access to the resources provided by the ONC Regional Extension Centers, which provide additional outreach and assistance to these providers.

5. **Physicians have testified before this Committee that the health IT learning curve for physicians is so steep that after implementing health IT, they were not able to resume their previous patient load for up to two or more years. What efforts are underway, aside from the Regional Extension Centers, which may be overburdened, to provide technical assistance to small practice physicians who are implementing health IT?**

Answer: From CMS' perspective, as part of the national outreach effort, all providers participating in the Fee-for-Service Medicare program are receiving information directly from CMS through the Medicare Provider Network.

Additionally, CMS is partnering with other federal entities, such as the Health Resources and Services Administration (HRSA) Office of the National Coordinator for Health Information Technology (ONC), and prominent national stakeholders like the National Rural Health Association to provide information at events and other public forums to reach the local communities.

As an example, CMS and ONC conducted an educational webinar with HRSA that had nearly 1000 participants representing rural providers and Federally Qualified Health Center (FQHC) grantees. Further, our Regional Offices are aware of areas that do not have sufficient Internet connectivity to support health IT exchanges and local organizations that support the "small town" doctor. We use this information to tailor our outreach activities to reach providers in small practices in these areas. CMS plans to create materials that address the specific concerns of rural providers and educate them on both the programs and the means to acquire EHR technology. And lastly, our Regional Offices continue to collaborate with the Regional Extension Centers to assist in the education of the small practices across the country.

Also, as mentioned in prior questions, CMS publishes a wide variety of educational resources, including User Guides that provide step-by-step explanations for registering and attesting for the EHR Incentive Programs and Meaningful Use Specification Sheets that provide a comprehensive overview for each of the meaningful use objectives. CMS holds regular Open Door Forums via telephone that provide eligible professionals with an

opportunity to not only gain an overview of the EHR Incentive Programs, but also to ask questions and get answers directly from CMS experts. In addition, CMS is planning a number of educational resources that will be of particular assistance to small practices, including a "Beginner's Guide to Meaningful Use."

6. **Please provide a specific breakdown of the kinds of technical assistance that the RECs are providing to small medical providers.**

Answer: All 62 Regional Extension Centers (RECs) are functional and each submitted a business plan for sustainability that includes providing fee-based services, as well as shared hosting services.

While the overall goal of the program is to assist 100,000 priority providers achieve meaningful use by 2014, each REC has developed its own outreach plans to assist providers in its service area. As of June 2011, the RECs had signed up more than 75,000 providers to participate in the program, and are averaging more than 6,000 new enrollees per month.

RECs are focusing their efforts on supporting providers in priority settings, which historically have had difficulty in implementing EHR systems. These include individual and small practices and represent 48% of providers currently enrolled in the program. Approximately 16% of small practice providers enrolled with RECs are in rural areas, 45% are in metro (suburban and exurban) areas, and 39% are in urban areas. Among the more than 10,000 small practices enrolled in REC programs as of May, 2011, the average size is 2 providers per practice.

Community health centers (CHCs) and rural health clinics (RHCs) represent 28% of the current REC enrollment. Among the more than 1,600 CHCs and RHCs enrolled in the REC program as of May 2011, the average size is 14 providers for CHCs and 5 providers for RHCs. Providers in public, rural, and critical access hospitals represent 13% of the providers enrolled by the RECs. The remaining 11% of enrollees are from medically underserved or other settings.

RECs provide core services to small practice providers to assist them in achieving meaningful use. These core services include assistance with education about EHR systems, implementation best practice, and general information about meaningful use. Each REC customizes the services it offers to meet the needs of the local providers. North Carolina REC, for instance, has educated more than 2,000 providers on meaningful use (MU) at over 70 group presentations in the past year.

Another service provided by the RECs is practice needs assessments, which are designed to capture gaps in implementation barriers. Ohio REC developed an online assessment tool with Welch Allyn which has helped more than 420 providers in small practices to identify potential barriers to implementation and has been the basis for the vendor demos.

The RECs are also able to assist small practice providers to address financial constraints they experience while implementing an EHR system. The Georgia REC has partnered with Flagstar Bank on a program to provide qualified applicants with 100 percent financing of the hardware, software, and installation costs with the total soft cost not to exceed 30%. The total soft cost consists of non-hardware fees such as appraisals, building permits and insurance.

Another core service that is supported by the RECs is workforce support. RECs are working with community colleges supported by ONC to place students who are trained in new health IT fields such as practice workflow redesign or EHR implementation. These students provide practices with the services they need to properly implement the EHR systems. The RECs in Iowa and Kansas are partnering with community colleges and employers to hold job fairs to connect small practices to locally trained health IT students.

Many RECs also provide their providers with assistance in quality improvement. This is very important because many providers do not understand how to fully take advantage of the new capabilities that are incorporated in their EHR systems, and they need to report certain clinical quality measures as part of achieving meaningful use. The NYC REC, for instance, has assisted more than 130 small practices to receive NCQA Patient Centered Medical home recognition.

7. **What is your estimate of the average Medicare payment incentive that a small practice physician can expect to receive for participating in the EHR and e-prescribing programs? How much of the actual cost of an average health IT system would these incentives offset?**

Answer: CMS is unable to track physicians according to practice size, so it is not possible at this time for us to estimate payments for small-practice providers. If an eligible professional begins participation in the Medicare EHR Incentive Program in 2011 or 2012, they could earn incentives that total $44,000 over five years. The Medicaid EHR Incentive Program is even more generous with incentives that could total $63,750 over six years. In addition, for 2011 and 2012, a successful electronic prescriber under the eRx Incentive Program could earn an incentive equal to 1.0% of an eligible professional's total estimated Medicare PFS allowed charges for covered professional services furnished during the respective reporting period. This decreases to 0.5% for 2013. CMS notes, however, that even though an eligible professional may be participating in the eRx Incentive Program, the eligible professional cannot earn an eRx incentive if the eligible professional receives an incentive payment under the Medicare EHR Incentive Program for that year.

While the EHR Incentive Program payments were not intended to cover all of the expenses involved in implementing an EHR, the incentive payments will help alleviate a majority of the expenses related to implementation.

To estimate the cost impact of an EHR system on healthcare providers, we used information from four studies. Based on these studies, we continue to estimate that for eligible professionals (EPs), the average adopt/implement/upgrade cost is $54,000 per physician FTE, while annual maintenance costs average $10,000 per physician FTE. The studies we used to estimate costs included the purchase and installation of hardware and software, training, as well as productivity losses associated with implementation and training. Each of these studies was conducted several years ago, and did not control for type of EHR, functionality, physician practice type or size. One study estimates the average cost per physician for implementation is approximately $35,000[1]. A similar study of community health centers estimated costs to average $54,000 per physician FTE[2]. In this study, the authors explained that implementation costs varied between entities for hardware, software, installation, and training. After implementation, there were ongoing operating costs estimated at $21,000 per year for a practice of four physicians. The Congressional Budget Office (CBO) paper[3], in attempting to estimate the total cost of implementing health IT systems in office-based medical practices, recognized the complicating factors of EHR types, available features and differences in characteristics of the practices that are adopting them. The CBO estimated a cost range of $25,000 to $45,000 per physician. In the CBO study, operating costs added $3,000 to $9,000 per physician per year. Finally, a Medical Group Management Association (MGMA) study[4] financed by the Agency for Healthcare Research and Quality (AHRQ)[5], stated that the average purchase and implementation cost of an EHR could be $32,606 per FTE physician. Maintenance costs were an additional $1,500 per physician, per month, or $18,000 per year. Smaller practices had the highest implementation costs per physician at $37,204.

8. **What percentage of small practice physicians have adopted 1) basic and 2) full service health IT systems? What recommendations do you have for encouraging**

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[1] Greiger et al. 2007, APilot Study to Document the Return on Investment for Implementing an Ambulatory Electronic Health Record at an Academic Medical Center
http://www.journalacs.org/article/S1072-7515%2807%2900390-0/abstractarticle-footnote-1s

[2] Pollard, C *et al.* (2009) "Electronic patient registries improve diabetes care and clinical outcomes in rural community health centers" Journal of Rural Health 25(1):77–84

[3] CBO study "Evidence on the Costs and Benefits of Health Information Technology," May 2008,
http://www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf

[4] Assessing Adoption of Effective Information Technology by Medical Group Practices," Medical Group Management Association (MGMA) Center for Research
http://content.healthaffairs.org/content/24/5/1323.full

[5] *Research Finds Low Electronic Health Record Adoption Rates for Physician Groups.* Press Release, September 14, 2005. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/news/press/pr2005/lowehrpr.htm

wider adoption of health IT systems among small providers, who often feel disadvantaged and penalized in the transition?

Answer: As noted previously, CMS is unable to track providers according to practice size, so we are not able to provide any estimates relating to small-practice physicians' adoption of EHR technology. However, CMS has conducted numerous focus groups, and through these we know that the challenges facing small practice providers can be significant. In addition to the educational resources that CMS has offered and continues to offer to physicians, the Office of the National Coordinator's Regional Extension Centers were established specifically to encourage the wider adoption of health IT among small practice providers and to provide specialized services that help these providers overcome the challenges of implementing an EHR. CMS's Regional Offices also conduct a large number of local educational workshops and seminars that reach a large number of small practice providers, in addition to working directly with RECs to educate these physicians. To date, more than 400 workshops have been held.

We have heard from numerous sources that although the initial implementation costs are high and productivity may fall for a week or two, in the long run providers have increased efficiencies that more than compensate for the initial investment.

9. **The Committee hears many concerns about interoperability. HHS developed a basic framework of standards and interoperability. What is CMS doing to continually solicit stakeholder input on standards and implementation to ensure that a system a provider purchases today will work with others?**

Answer: Building upon the foundations of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the Office of the National Coordinator has been working closely with our Federal advisory committees – the HIT Standards Committee (HITSC) and the HIT Policy Committee (HITPC) – to provide a way for stakeholders and the public to participate in the standards and implementation process. Consisting of key stakeholders such as providers, doctors, Federal partners and vendors, the HITSC has publicly met 27 times in the past two years. In addition, key stakeholders participate on five HITSC workgroups to develop recommendations to the HITSC. The workgroups are: Clinical Operations, Clinical Quality, Privacy and Security, Implementation, and Vocabulary Task Force. For instance, the Clinical Operations workgroup, which has met 17 times in the past two years, discusses requirements for EHR certification criteria, standards, and implementation specifications related to clinical operations. This workgroup also addresses vocabulary subsets and value sets as facilitators and enablers of "meaningful use." All of these workgroups meet periodically and are open to the public to discuss topics that are relevant to standards and implementation concerns.

In addition, ONC has developed the Standards and Interoperability (S&I) framework, which engages key stakeholders and the public on issues related to standards and interoperability. The S&I framework allows for focused collaboration with stakeholders

on harmonizing existing standards and solving the important problems of interoperability and health information exchange through real world implementations, demonstrations, pilots and testing. Currently, there are 275 committed members and 179 organizations represented under the S&I framework initiatives.

ONC supports multiple projects through the S&I framework. One such project is the Direct Project, which was launched in March 2010 to solve standards issues related to the peer-to-peer exchange of clinical information. Direct Project's open, transparent and inclusive process enabled the broader community, including all interested private and public sector participants, to engage in developing, testing, piloting and driving adoption of the new standard among care communities and health IT vendors. Today there is commitment by 50+ health IT vendors, 90 percent of the health IT market, to implement the Direct Project specification, further enabling the promise of broad interoperability among a wide variety of healthcare industry participants nationwide. Currently, there are 669 registered users on the Direct Project wiki site and (as of the end of February) there are 89 organizations represented.

10. **A 2012 study in the Boston University Journal of Science and Technology Law found that privacy concerns were a key obstacle to health IT adoption. The HITECH Act strengthened the Health Insurance Portability and Accountability Act (HIPAA) privacy measures, but it offered minimal guidance on implementation of the new provisions. What is CMS doing to ensure the security and privacy of electronic health records, for both patients and medical providers? What flexibility will be included for small practice physicians, who are likely to face greater challenges to implementation?**

Answer: Ensuring strong privacy protections for patients and providers is fundamental to the success of EHR adoption and meaningful use. HHS issued a proposed rule on July 14, 2010, designed to strengthen the privacy and security protections for health information established under HIPAA. These privacy and security protections form an important base for EHR acceptance and use. CMS' and ONC's final rules related to meaningful use complement this recent proposed rule. We have also specifically made privacy and security requirements a core requirement of meaningful use.

The HITECH Act specifically mandated the Office for Civil Rights to conduct a national and multi-language public education campaign that includes educating individuals about their HIPAA rights. While CMS is not mandated to fulfill this work, we are committed to educating our beneficiaries on their rights and protections of their health records, whether in paper or electronic form. CMS has numerous publications, information on www.medicare.gov and an ombudsman office to assist in these matters. In addition, information promoting health IT and privacy is included in the Medicare & You Handbook, which is mailed to all 43 million Medicare beneficiary households each year. To specifically address EHR privacy and security, CMS staff are prepared to answer questions about privacy protections through 1-800-MEDICARE and we will amplify

messages and materials created by the Office for Civil Rights to our Medicare and Medicaid beneficiaries.

11. Several organizations have mentioned the need for a "one stop" website for health IT. Have HHS and CMS collaborated on one site? What outreach efforts has CMS undertaken to small practices on this, and what input has been sought from them?

Answer: CMS has established a website containing information on the EHR Incentive Programs at www.cms.gov/EHRIncentivePrograms which provides detailed information about eligibility, requirements, how to participate, how to register and attest for meaningful use, and other information in more digestible portions to assist providers with learning and understanding the information.

In addition, ONC has established a comprehensive website that links to the CMS website for information on the incentive programs and provides additional information on the full spectrum of health IT activities including certification regulations and guidance, the Certified Health IT Products List (CHPL), information on privacy and security, standards and interoperability, and other HITECH programs and resources.

CMS also facilitates, in conjunction with ONC, a bi-weekly hospital and provider stakeholder call to share information and receive feedback from the field. The stakeholders are committed to helping in the educational effort to their constituents. Finally, CMS continues to conduct training for multiple audiences, including rural providers, through open door forums, CMS-hosted trainings, presentations at key stakeholder conferences and webinars, partnering with ONC both at the national and local level.

As part of the national outreach effort, all providers participating in the Fee-for-Service Medicare program are receiving information directly from CMS through the Medicare Provider Network. Additionally, CMS is partnering with other federal entities, such as HRSA and ONC, and prominent national stakeholders like the National Rural Health Association to provide information at events and speaking engagements to reach the local communities.

As an example, CMS and ONC conducted an educational webinar with HRSA that had nearly 1000 participants representing rural providers and FQHC grantees. Our Regional Offices are aware of areas that no not have sufficient Internet connectivity to support health IT exchanges and local organizations that support the "small town" doctor. We use this information to tailor our outreach activities to reach small practice providers in these areas.

12. On May 27, CMS announced that Medicare EHR incentive payments totaling $75 million were issued to over 280 providers who signed up for the program in the first two weeks. Of those payments, how many were issued to small practice physicians?

Answer: Again, because CMS does not track any practice information when reimbursing physicians, we are unable to provide information according to practice type. Unfortunately, this means that we are not able to provide information on registration, attestation, payment, or participation according to practice size.

13. **At the Subcommittee's June 2 hearing, Sasha Kramer, M.D., who owns a solo dermatology practice, testified that two years ago, she invested in a $41,349 EHR system, using a $19,964 state grant and $25,385 of her own business cash reserves. After devoting eighty hours to researching and selecting the vendor and system, and eighty hours of staff training, her patient load was reduced from four patients per hour to one patient per hour during the system's implementation. One and a half years later, her software vendor was acquired by another company, and she was informed that the new vendor's products would no support her current network platform. As a result, she now faces the purchase of a completely new system. Will CMS consider delaying the meaningful use penalties to early adopters of health IT until such time as an interoperable system of health IT is in place? If not, will CMS provide a safe harbor to protect these early adopters?**

Answer: Because the timeline for the payment adjustments was established in the HITECH Act provisions of the Recovery Act, CMS does not have the flexibility to delay the payment adjustments absent a change in the law.

14. **Will CMS grandfather in physicians who are nearing retirement and exempt them from financial penalties so that they are not forced into early retirement?**

Answer: The EHR Incentive Programs are voluntary in nature. No physician is subject to the payment adjustments until 2015, and beginning in 2015, only those Medicare eligible professionals who do not demonstrate meaningful use would receive an adjustment to their fee schedule amount of 1 to 2 percent for 2015, 2 percent for 2016, and 3 percent for 2017 and each subsequent year (except, for 2018 and subsequent years, payment adjustments may continue to increase by 1 percent per year, to no more than 5 percent, if the Secretary makes certain findings about low proportions of meaningful use). Given this timeline, CMS does not believe the payment adjustments would force any physician into retirement. However, we are continuing to develop policies as they pertain to the payments.

15. **We have heard from small practice physicians that the numerous health IT regulatory requirements, deadlines and penalties are difficult for them to track, decipher and comply with. At the June 2 hearing, Dr. Sasha Kramer testified that for early adopters who have a contract with a service provider to meet 2011 and 2012 requirements under phase one, there will be a short window between the release of phase two requirements and the deadline for meeting them in 2013. She further testified that physicians are facing financial penalties on their annual Medicare billings of seven percent by 2012 of they are not in compliance with the meaningful use criteria, the physician quality reporting system and e-prescribing.**

This seven percent could be a practice's entire profit margin, and could mean the difference between a practice staying open or closing. What is CMS doing to minimize the burden of compliance for small practice physicians?

Answer: It is important to note that many of these incentive programs provide for escalating penalties over time, so a provider would not be subject to the full penalties in 2012 and would likely not be subject to the full penalties associated with each program unless they had failed to comply with requirements over a number of years.

We know that the alignment of incentive and reporting programs is a primary concern for providers, and in recognition of this, aligning these programs is a high-level initiative at CMS. We are currently exploring the various ways in which we can align requirements across the EHR Incentive Programs, the Physician Quality Reporting System (PQRS), the E-Prescribing Incentive Program, and other quality reporting programs. Initial alignment between the EHR Incentive Program, PQRS, and e-Prescribing was proposed in the July 1, 2011, the Medicare Physician Fee Schedule proposed rule for calendar year 2012. CMS is currently collecting feedback on those proposals, but we are hopeful that aligning quality measures and reporting methods across these programs will minimize the burden of compliance on all providers.

16. **Does CMS plan to assess physician participation rates and barriers to participation in Stage 1 of the meaningful use EHR incentive program?**

Answer: Yes. We are in the process of analyzing data related to Stage 1 participation now, and we will use that data—along with feedback from healthcare associations, providers, and the HIT Policy Committee – to inform our thinking about Stage 2 meaningful use requirements for the upcoming NPRM. During the regulatory process we will solicit public feedback, and will carefully consider all of the comments that we receive before finalizing the regulation. CMS is listening closely to provider and vendor concerns about the criteria for Stage 2 of the Medicare and Medicaid EHR Incentive Programs. Our goal continues to be to assist providers in achieving meaningful use while avoiding unnecessary burdens. CMS will carefully evaluate this stakeholder input as we work towards our goal of meeting our policy priorities and supporting the health care community's ability to meaningfully use certified EHR technology through flexible and feasible regulations.

17. **If there are additional barriers to successful participating in the meaningful use of the EHR incentive program, will CMS create additional flexibility in the requirements? What about for small practice physicians in particular?**

Answer: CMS received numerous comments from providers, advocates, and Congress on the proposed rule for Stage 1 of the EHR Incentive Programs. We carefully evaluated these comments and tried to accommodate concerns in a way that provides flexibility for providers while moving forward on the adoption and meaningful use of EHR technology. We believe that we were able to accommodate the majority of provider comments in

some way before finalizing the rule for Stage 1. As we begin to prepare our Stage 2 regulations, we continue to be sensitive to the need for flexibility and will again seek public comment through the rulemaking process.

It is important to note that CMS did not finalize Stage 2 or Stage 3 requirements in the Stage 1 final rule. We did provide some specificity about Stage 2; however, we do not expect to address the details of other stages until later rulemaking. There are several reasons for this:

1. We want to get results from Stage 1 to help us determine if the requirements that we have set are appropriate.
2. Much of the requirements for later stages will be dependent on infrastructure improvements that are anticipated over the next several years due to HITECH funding.
3. The Stage 1 MU requirements attempt to harmonize the Medicare and Medicaid program requirements. However we recognize that beginning in 2015 the program difference, including meaningful use, will become much greater due to the Medicare payment adjustments and the fact that Medicare incentive payments end in 2016, while Medicaid has no payment adjustments and continues through 2021.

18. Will CMS survey users of EHRs to assess how effective the EHR products are in helping physician to achieve meaningful use requirements?

Answer: CMS regularly conducts focus group and survey research to determine the knowledge level of providers regarding the EHR Incentive Programs and meaningful use. We use this research not only to develop educational resources but also for developing outreach strategies and for determining future program directions. We will continue to conduct this research to determine the effectiveness of EHR technology in helping providers meet the requirements of the EHR Incentive Programs, and we can share the results of that research as we move forward with implementation of the program.

The ONC conducts additional research on EHR adoption as well as certification criteria. CMS and ONC will continue to work closely together to make sure that physicians are fully aware of all certified EHR products that will help them meet meaningful use criteria.

19. Please provide any recent studies CMS has done on whether EHRs have helped to reduce medical errors, reduce paperwork, increase efficiency and achieve better health outcomes. Will CMS survey users of EHRs to assess physician views of the efficacy of EHRs?

Answer: CMS has contracted with Mathematica Policy Research, Inc. (MPR) to conduct an eight-year independent evaluation of the Electronic Health Records demonstration. The EHR demonstration targets small to medium-sized primary care practices and just completed its first two years. The evaluation will assess the degree to which the demonstration met the goals of improved quality of care and reduced Medicare costs

through the adoption and use of EHRs in small to medium sized primary care practices. MPR will report the evaluation findings to CMS within one year after the end of the demonstration.

Also, the evaluation of the Medicare Care Management Performance (MCMP) demonstration that ended last July will include results of a physician survey that included questions on the use of EHRs and barriers to adoption and use.

Chairwoman Ellmers
Subcommittee on Healthcare and Technology
Questions for the Record
Farzad Mostashari, M.D., ScM.
Department of Health and Human Services
"Not What the Doctor Ordered: Health IT Barriers for Small Medical Practices"
June 2, 2011

1. What is your estimate of the average Medicare payment incentive that a small practice can expect to receive for participating in the EHR and e-prescribing programs? How much of the actual cost of a health IT system would these incentives be expected to offset?

The Centers for Medicare & Medicaid Services (CMS) maintains the information on Medicare payment incentives. CMS is unable to track physicians according to practice size, so it is not possible at this time for us to estimate payments for small-practice providers. If an eligible professional begins participation in the Medicare EHR incentive program in 2011 or 2012, they could earn incentives that total $44,000 over five years. The Medicaid incentive program is even more generous with incentives that could total $63,750 over six years.

While the EHR Incentive Program payments were not intended to cover all of the expenses involved in implementing an EHR, the incentive payments will help alleviate a majority of the expenses related to implementation.

To estimate the cost impact of an EHR system on healthcare providers, we used information from four studies. Based on these studies, we continue to estimate that for EPs, the average adopt/implement/upgrade cost is $54,000 per physician FTE, while annual maintenance costs average $10,000 per physician FTE. The studies we used to estimate costs included the purchase and installation of hardware and software, training, as well as productivity losses associated with implementation and training. Each of these studies was conducted several years ago, and did not control for type of EHR, functionality, physician practice type or size. One average estimate of the cost per physician for implementation is approximately $35,000[1]. A similar study of community health centers estimated costs to average $54,000 per physician FTE[2]. In this study, the authors explained that implementation costs varied between entities for hardware, software, installation, and training. After implementation, there were ongoing operating costs estimated at $21,000 per year for a practice of four physicians. The Congressional Budget Office (CBO) paper[3], in attempting to estimate the total cost of implementing health IT systems in office-based medical practices, recognized the complicating factors of EHR types, available features and

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differences in characteristics of the practices that are adopting them. The CBO estimated a cost range of $25,000 to $45,000 per physician. In the CBO study, operating costs added $3,000 to $9,000 per physician per year. Finally, a Medical Group Management Association (MGMA) study[4] financed by the Agency for Healthcare Research and Quality (AHRQ)[5], stated that the average purchase and implementation cost of an EHR could be $32,606 per FTE physician. Maintenance costs were an additional $1,500 per physician, per month, or $18,000 per year. Smaller practices had the highest implementation costs per physician at $37,204.

2. **Do you know what percentage of small providers have adopted health IT systems? What recommendations do you have for encouraging wider adoption of health IT systems among small providers, who often feel left behind, disadvantaged and penalized in the transition to EHRs and e-prescribing?**

2010 data from the National Center for Health Statistics indicate that roughly 22 percent of physicians in practice sizes of 10 or fewer physicians have adopted at least a "basic" electronic health record. Comparatively, nearly 50 percent of physicians in practice sizes of 11 or more physicians have a system with at least the same capabilities in place. For hospitals, 2010 data from the American Hospital Association show that only 14 percent of small hospitals have a "basic" record while this number increases to 24 percent among medium and large bed institutions. These gaps highlight the important roles ONC programs are playing in helping all eligible providers adopt and implement electronic health records. Because of this gap, our Regional Extension Centers are particularly focused in helping small primary care providers and critical access hospitals select, adopt and implement electronic health records and achieve meaningful use. Our Workforce development programs are tasked with training ready and available staff to help implement and manage systems across all different types of settings. Never before have so many resources been available to support small providers implementing electronic health record systems, and we are making sure small as well as larger providers take advantage of them.

3. **We hear many concerns from providers about interoperability. HHS developed a basic framework of standards and interoperability. What is HHS doing to continually solicit stakeholder input on standards and implementation, and ensure that a system that a provider purchases today will work with other systems?**

Building upon the foundations of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the Office of the National Coordinator (ONC) has been working closely with our Federal Advisory Committees (FACA) – the HIT Standards Committee (HITSC) and the HIT Policy Committee (HITPC) – to provide a way for stakeholders and the public to

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[4] Assessing Adoption of Effective Information Technology by Medical Group Practices," Medical Group Management Association (MGMA) Center for Research *http://content.healthaffairs.org/content/24/5/1323.full*

[5] *Research Finds Low Electronic Health Record Adoption Rates for Physician Groups.* Press Release, September 14, 2005. Agency for Healthcare Research and Quality, Rockville, MD. *http://www.ahrq.gov/news/press/pr2005/lowehrpr.htm*

participate in the standards and implementation process. Consisting of key stakeholders such as providers, doctors, Federal partners and vendors, the HITSC has publicly met 27 times in the past two years. In addition, key stakeholders participate on five HITSC workgroups to develop recommendations to the HITSC. The workgroups are: Clinical Operations, Clinical Quality, Privacy and Security, Implementation and Vocabulary Task Force. For instance, the Clinical Operations workgroup, which has met 17 times in the past two years, discusses requirements for EHR certification criteria, standards, and implementation certifications related to clinical operations. This workgroup also addresses vocabulary subsets and value sets as facilitators and enablers of "meaningful use." All of these workgroups meet periodically and are open to the public to discuss topics that are relevant to standards and implementation concerns.

In addition, ONC has developed the Standards and Interoperability (S&I) framework, which engages key stakeholders and the public on issues related to standards and interoperability. The S&I framework allows for focused collaboration with stakeholders on harmonizing existing standards and solving the important problems of interoperability and health information exchange through real world implementations, demonstrations, pilots and testing. Currently, there are 275 committed members and 179 organizations represented under the S&I framework initiatives.

ONC supports multiple projects through the S&I framework. One such project is the Direct Project, which was launched in March 2010 to solve standards issues related to the peer-to-peer exchange of clinical information. Direct Project's open, transparent and inclusive process enabled the broader community, including all interested private and public sector participants, to engage in developing, testing, piloting and driving adoption of the new standard among care communities and health IT vendors. Today there is commitment by 50+ health IT vendors, 90 percent of the health IT market, to implement the Direct Project specification, further enabling the promise of broad interoperability among a wide variety of healthcare industry participants nationwide. Currently, there are 669 registered users on the Direct Project wiki site and (as of the end of February) there are 89 organizations represented.

4. **A 2010 study in the Boston University *Journal of Science and Technology Law* found that privacy concerns are a key obstacle to health IT adoption. The HITECH Act strengthened the Health Insurance Portability and Accountability Act (HIPAA) privacy measures, but it offered minimal guidance on implementation of the new provisions. What is HHS doing to ensure the security and privacy of electronic health records, for both patients and medical providers? Will there be flexibility for small providers, who may face more challenges to implementation?**

The Department of Health and Human Services (HHS) has taken a number of steps to help ensure the privacy and security of electronic health records. First, we are in the process of finalizing rules that will detail how to implement the heightened privacy protections established in HITECH including: extending key requirements of the Health Insurance Portability and Accountability Act (HIPAA) to business associates; restricting the sale of protected health information; and enabling patients to prohibit the disclosure of their health information to health plans when they pay out of pocket.

HHS recognizes that providers may need guidance to implement these requirements, as well as other means to maintain the privacy and security of electronic health records. Consequently, HHS is undertaking a number of efforts including the following:

- Producing new guidance documents and training materials to facilitate compliance with the HIPAA Security Rule, including guidance on performing security risk assessments, producing educational materials such as interactive training modules on computer security and cybersecurity; education on backing up systems and recovering from system failures, detecting and reporting potential computer intrusion attempts; and providing a more automated approach to security in order to reduce the burden on small providers.

- Using the Health IT Regional Extension Centers (RECs), as a way to educate providers about privacy and security. These efforts include, among other things, providing materials, such as those described above, and hosting a Privacy and Security Community of Practice, where REC participants assist each other in identifying common issues and best practices in implementing privacy and security measures.

The HIPAA Security Rule provides flexibility for small providers. The Rule is a flexible, scalable framework for risk management and recognizes that one size does not fit all. Implementation of security features is to be done on the basis of a risk assessment in which the provider identifies areas of risk in their practice and mitigates those risks. The costs of such a risk analysis can vary from self-administered use of ONC's free risk assessment tool to more costly endeavors. Providers can also use ONC's capability and readiness assessment to gauge their operational readiness for secure EHR use. They can also use ONC's Cybersecurity Checklist, which was specifically developed for small practices. All of these tools are available from the RECs and the Cybersecurity Checklist is available from ONC's website.

Only after a risk analysis is performed can mitigation plans be made. What these mitigation plans consist of will vary depending on the type of EHR used; a locally-hosted software versus one hosted by a vendor. Risk mitigation for these systems would likely focus on procedural security, which only has soft costs such as setting up proper access controls, identifying who is accountable for security, verifying that physical controls are in place to prevent unauthorized access, training the staff on correct procedures, and documenting their policies related to security.

There are other risks, however, which will require mitigations that cannot be met by locally-hosted solutions. For vendor-hosted solutions, the small practice is still required to do the risk analysis. However, the mitigations of some risks, such as full-disk encryption (which protects locally stored data) may be avoided. Since vendor-hosted solutions are offered on the basis of a contract, known as a Service Level Agreement (SLA), it is prudent for providers to also invest in a professional, legal review of the SLA to ensure they fully understand the SLA's implications for the security of patient data.

Small practices can retain control of managing these costs. Implementing security features does need not be financially onerous nor require investment in high-cost technology. For a two to three physician practice, the costs would be similar to those incurred in setting up a home computer network securely. Standard activities could include installing and updating the anti-

virus software, keeping the operating system patched by turning on auto-update features, making sure that wireless routers have the encryption turned on, and turning on the firewall protection included in the operating system or browser. Providers who are unfamiliar with these functions can obtain help at a modest cost either from an REC or from a reasonably-priced third-party consultant (available at many stores that sell home computers).

5. **Several organizations have mentioned the need for a "one stop" website for health IT. Have HHS and CMS collaborated on one site? What outreach efforts to small practices have HHS and CMS undertaken on this and what input have you sought from them?**

The Office of the National Coordinator (ONC) has worked collaboratively with other agencies within HHS, including CMS, Office for Civil Rights (OCR) and the Agency for Healthcare Research and Quality (AHRQ), to revise its existing website by September 1, 2011 that it will soon become a one-stop-shop consumer and provider-oriented website called healthIT.gov. ONC has established a comprehensive website that links to the CMS website for information on the incentive programs and provides additional information on the full spectrum of health IT activities including certification regulations and guidance, the Certified Health IT Products List (CHPL), information on privacy and security, standards and interoperability, and other HITECH programs and resources. The site also links to OCR, AHRQ, and the National Institute of Standards and Technology. ONC's revised website, which will be available September 1, 2011, will provide doctors, other health care providers and consumers with the resources they need to make meaningful use of electronic health records and other health IT applications to improve patient health.

We have obtained input from small practices and consumers through focus groups, card sort exercises, and heuristic evaluation, and through the work done by the National Health Information Technology Research Center, which is assisting with the web site content development. The National Health Information Technology Research Center funded by ONC, was created to enable 62 national Regional Extension Centers to assist providers, including small practices, to make the transition to electronic health records. Indeed, ONC's goal in revising healthIT.gov was to make it a "virtual" Regional Extension Center that will assist small practices and other providers over the Internet.

CMS has also established a website containing information on the EHR Incentive Programs at www.cms.gov/EHRIncentivePrograms, which provides detailed information about eligibility, requirements, how to participate, how to register and attest for meaningful use, and other information in more digestible portions to assist providers with learning and understanding the information.

6. **Approximately one-third of the $2 billion in HITECH Act funds has been allocated to establish 62 Regional Extension Centers (REC) across the country. The RECs are intended to play a central role in promoting EHR adoption and meaningful use, by providing outreach, education, and technical assistance to medical providers. What is the status of the REC program? Are all 62 RECs functional? Will they become economically self-sufficient? If so, how? What types of services are they providing to small physician**

practices? How many physicians have registered with RECs? Of those, how many are small physician practices?

All 62 Regional Extension Centers (REC) are functional and each submitted a business plan for sustainability, that includes providing fee-based services, as well as shared hosting services. While the overall goal of the program is to assist 100,000 priority providers achieve meaningful use by 2014, each REC has developed its own outreach plans to assist providers in its service area. As of June 2011, the RECs had signed up more than 75,000 providers to participate in the program, and are averaging more than 6,000 new enrollees per month The REC program is tracked for success and paid for performance in achievement of three milestones: provider registration with the REC, provider implementation of a certified EHR, and provider achievement of meaningful use criteria.
RECs are focusing their efforts on supporting providers in priority settings, which historically have had difficulty in implementing EHR systems. These include individual and small practices and represent 48% of providers currently enrolled in the program. Approximately 16% of small practice providers enrolled with RECs are in rural areas, 45% are in metro (suburban and exurban) areas, and 39% are in urban areas. Among the more than 10,000 small practices enrolled in REC programs as of May, 2011, the average size is 2 providers per practice.

Community health centers (CHCs) and rural health clinics (RHC) represent 28% of the current REC enrollment. Among the more than 1,600 CHCs and RHCs enrolled in the REC program as of May 2011, the average size is 14 providers for CHCs and 5 providers for RHCs. Providers in public, rural, and critical access hospitals represent 13% of the providers enrolled by the RECs. The remaining 11% of enrollees are from medically underserved or other settings.

RECs provide core services to small practice providers to assist them in achieving meaningful use. These core services include assistance with education about EHR systems, implementation best practice and general information about meaningful use. Each REC customizes the services they offer to meet the needs of the local providers and are strongly encouraged to use program flexibility to creatively meet individual market or emerging needs. These myriad methods and approaches are shared and vetted using the Community of Practice mechanism, to build a learning community among the RECs to support provider adoption and meaningful use. Success in these core services is evaluated alongside direct REC technical assistance services, ultimately measured by each REC's progress in the programmatic milestones discussed previously. Below are two examples of representative core services provided by RECs.

The North Carolina REChas educated more than 2,000 providers on meaningful use at over 70 group presentations in the past year. Another service provided by RECs is practice needs assessments, which are designed to capture gaps in implementation barriers. The Ohio REC developed an online assessment tool with Welch Allyn which has helped more than 420 providers in small practices to identify potential barriers to implementation and has been the basis for the vendor demos.

The RECs are also able to assist small providers to address financial constraints they experience while implementing an EHR system. The Georgia REC has partnered with Flagstar Bank on a program to provide qualified applicants with 100% financing of the hardware, software, and

installation costs with the total soft cost not to exceed 30%. The total soft cost consists of non-hardware fees such as appraisals, building permits and insurance.

Another core service that is supported by the RECs is workforce support. RECs are working with community colleges supported by ONC to place students who are trained in new health IT fields such as practice workflow redesign or EHR implementation. These students provide practices with the services they need to properly implement the EHR systems. The RECs in Iowa and Kansas are partnering with community colleges and employers to hold job fairs to connect small practices to locally trained health IT students.

Many RECs also supply their providers with assistance in quality improvement. This is very important because many providers do not understand how to fully take advantage of the new systems that are incorporated in their EHR systems and they need to meet certain quality measures prior to achieving meaningful use. The New York City REC, for instance, has assisted more than 130 small provider practices to receive the National Committee for Quality Asssurance Patient Centered Medically home recognition.

Sustainability will derive from delivering tangible value to providers around health IT adoption and meaningful use, as well as other services. ONC supports RECs by providing the following assistance (examples are not fully inclusive): 1) support to specialists and other providers, such as behavioral health specialists and optometrists; 2) support in purchase negotiations with hardware and software service providers ; and 3) pay for performance initiatives.

7. **Research has shown that implementation of EHR systems can impede the workflow in a physician office, at least initially. Paper records may need to be converted to electronic records, staff must be trained, and it takes time for a physician to become accustomed to using the new system. Do you have any data that shows how long it takes a physician office to bring a new system online and become fully functional? What can physicians, especially those in small practices, do to minimize this process?**

   A study in the March 2011 issue of Health Affairs found the implementation team for an average, five-physician practice needed approximately four months to prepare for and successfully implement an electronic health record system where "end users" in the same average practice, which includes physicians, other clinical staff, and nonclinical staff needed roughly one month to successfully prepare for use of the record system in clinical encounters. Other studies have found both small and large practices can recapture and improve on productivity and begin experiencing operating cost savings from their EHR relatively soon after the investment.[i,ii] Physicians, especially those in smaller practices, must recognize that proper implementation is essential to the long term quality improvements and cost-savings gained from electronic health records. Physicians are also encouraged to take advantage of the resources available to them, especially our Regional Extension Centers, to help them select, adopt, and implement the proper electronic health record system to meet their needs.

8. **Providers have been urged to adopt certified EHR systems. How certain are you that these certified systems will meet the Stage 2 and Stage 3 certification criteria? What specific steps are being taken to ensure that they will?**

The stages of meaningful use were set out to incrementally introduce increasingly more comprehensive use of certified EHR technology over time. In order for that to occur, the EHR technology itself will need to be able to keep pace with the capabilities health care providers must demonstrate in future stages of meaningful use. Thus, it is unlikely that an EHR technology designed and certified in 2010 or 2011, without any updates, will be able to support a health care provider's ability to achieve subsequent meaningful use stages. To help alleviate the burden these upgrades could create, we included processes as part of our permanent certification program that permit EHR technology to be "gap certified." That is, when the Secretary of Health and Human Services adopts new and/or revised certification criteria in future rulemakings, gap certification will be available as a more efficient certification option for previously certified complete EHRs and EHR modules to be tested and certified to only the certification criteria that have changed.

9. **When the e-prescribing program began, it seemed to be a "starting point" for health IT towards the adoption of EHRs. Do we continue to need both programs? Please describe the advantages and disadvantages of having two separate programs.**

   Prior to the passage of the HITECH Act, the e-prescribing program (included as part of the Medicare Improvements for Patients and Providers Act) was the first program focused on increasing the adoption of health IT, specifically e-prescribing technology. With the passage of the HITECH Act, the e-prescribing incentive program will terminate at the end of 2014. We are working closely with our colleagues at CMS to coordinate and further align the requirements of both programs in an effort to make participation in both programs easier and more efficient for health care providers. OnJune 1, 2011, CMS published a notice of proposed rulemaking (75 FR 31547) to immediately enhance the programmatic alignment between the e-prescribing program's 2012 requirements and the EHR Incentive Program's requirements. CMS has since followed up this proposed rule with a similar set of proposals in a recent Medicare physician fee schedule 2012 proposed rule to make them apply to the remaining operating years of the e-prescribing program.

10. **The Federal Health Information Technology Strategic Plan of the Office of the National Coordinator 2011-1015 issued by your predecessor, Dr. Blumenthal, projects that adoption and information exchange through meaningful use of health IT will take place from 2011 through 2015. As we know, if one component of a patient's health care network – such as their family practice physician – is left out of the chain, the goal of an integrated health IT system fails. What is HHS doing to ensure that small providers are able to purchase health IT systems?**

    The REC program is dedicated to helping small practice providers to implement and meaningfully use EHR products. RECs are providing a number of different services that are designed to help small practice provider purchase the right EHR system for their practices needs. RECs have developed needs assessment tools which help providers to determine the optimal system for their needs. RECs are working to develop model contracts for providers to ensure that they get the services/support necessary to implement EHR systems. Many RECs are also

actively working with EHR vendors to oversee the implementation of EHR systems among their affiliated providers.

11. At the Subcommittee's June 2 hearing, Denise Elliott, D.P.M., who owns a solo practice, testified that although the Medicare incentives are helpful, they are insufficient to offset the bulk of a health IT system's cost. Dr. Elliott further testified that "requiring eligible providers to implement electronic health records in a 'meaningful way' over the next five years places an undue financial burden" on them. What is HHS doing to reduce the cost of systems and reduce the regulatory burden, specifically for small and rural providers?

RECs are working to assist their small providers to access financing so that they are able to adopt and implement the EHR systems that will allow them to progress towards achieving meaningful use criteria and receiving the corresponding incentive payments. Some REC are working with vendors to provide interest-free loans to providers participating in their program. Other RECs are working with commercial banks to help provide low-interest loans to providers. Georgia REC, for instance, has partnered with Flagstar Bank on a program to provide qualified applicants with 100 percent financing of the hardware, software, and installation costs. Under this program, a qualified provider will have access to 100 percent financing of the hardware, software and installation cost, with the total soft cost not to exceed 30 percent.

Fully understanding how a system operates and its full cost is important information for small practices that are implementing EHR systems. This information will ensure that they don't have unexpected costs, which can halt or delay implementation. The Maryland REC worked with the Maryland Health Care Commission (MHCC) to develop an *Electronic Health Record Product Portfolio* (Portfolio) to provide providers with evaluation and comparison information on EHRs. The Portfolio contains product information that will assist in the assessment of EHR systems. Vendors participating in the Portfolio have provided information regarding their EHR system, pricing, privacy and security policies (for Application Service Providers), and user references. The portfolio is revised annually in September and updated in March. The Portfolio is organized into two sections: vendors and vendor comparisonThe MHCC collection of 5-year pricing data for leading vendors can be found at http://mhcc.maryland.gov/electronichealth/ehr/ehrvendors.html.

Further, if an eligible professional begins participation in the Medicare EHR incentive program in 2011 or 2012, they could earn incentives that total $44,000. The Medicaid incentive program is even more generous with incentives that could total $63,750.

While the EHR Incentive Program payments were not intended to cover all of the expenses involved in implementing an EHR, the incentive payments will help alleviate a majority of the average expenses related to implementation.

12. At the Subcommittee's June 2 hearing, Sasha Kramer, M.D., who also owns a solo practice, testified that two years ago she invested in a $41,349 EHR system, using a $19,964 state grant and $25,385 of her own business cash reserves. After devoting eighty hours to researching and selecting the vendor and system, and eighty hours of staff training, her patient load was reduced from four patients per hour to one patient per hour during the

system's implementation. One and a half years later, her software vendor was acquired by another company and she was notified that the new vendor's products would not support her current network platform. As a result, her current system is inoperable, and she faces the purchase of a completely new system. What specific recourse is available to her for her current inoperable system, through the RECs or other sources?

ONC recognizes that this is an unfortunate situation and is aware that these events are taking place. There are a couple of options for Dr. Kramer. She can try to get the system certified through an available ATCB; however, the system will have to meet Meaningful Use (MU) and functionality criteria. The other option is to work with her local REC to receive technical assistance in the areas of data migration or formatting. The REC is in position to be a technical resource for Dr. Kramer.

13. **Some have suggested that all the requirements of each program – meaningful use, e-prescribing, Sustainable Growth Rate, etc. – be combined into one standard that could be plugged into any software, making it easier for providers to follow and comply. What are the advantages and disadvantages of this?**

It is important to recognize that the e-prescribing incentive program, Physician Quality Reporting System program, EHR incentive programs and others were created by Congress at different times and each developed with different goals. As such, the reporting measures and the methods for reporting on those measures were also different. To the extent possible, it would be beneficial to both the federal government and providers who are participating in these incentive programs to have greater consistency among measures and reporting methods. Within the guidelines of the law, ONC is actively engaged with CMS, AHRQ, OMB and other stakeholders to promote greater consistency and ease-of-use for providers in reporting measures and methods used for various incentive programs.
Aligning priorities for measures and the implementation of clinical quality measures (CQMs) is a critical HHS priority. ONC is working with leadership across HHS to align measurement priorities to support the National Quality Strategy as outlined in Patient Protection and Affordable Care Act. As part of this process, issues surrounding measure implementation are being addressed. Recently, an outcome of these discussions resulted in a pilot being included in a proposed rule from CMS. It offers providers an option to report one set of electronic QMs to fulfill the CQM requirements for both the Physician Quality Reporting System (PQRS) and the Medicare and Medicaid EHR Incentive Programs.

14. **Physicians have testified before this Committee that the health IT learning curve for physicians is so steep that after implementation of an EHR system, they were not able to resume their previous patient load for two or more years. What efforts are underway beyond the Regional Extension Centers, which may be overburdened, to provide technical assistance to physicians who are implementing health IT?**

A National Learning Consortium (NLC) has been developed to accommodate the technical assistance needs of physicians who are implementing health IT. The purpose of the NLC is to package and disseminate the lessons learned, best practices, tools and trainings that result from the experiences of the ONC outreach programs – Regional Extension Programs (Regional

Extension Centers and the Health IT Research Center), State Health Information Exchange Program and the Beacon Communities Program -- to the primary care provider community and the general public. The success of the NLC will depend in part on disseminating the knowledge in a fashion that guide and support health IT implementers and primary care physicians throughout the EHR implementation process. Additionally, the NLC will further support the entire provider community in packaging and disseminating knowledge related to meaningful use of EHRs.

A key component of meaningful use and health IT adoption for providers is exchanging information to support patient care. The State Health Information Exchange program is ensuring that every adopting provider has low cost, easy to implement exchange options to support meaningful use requirements such as exchanging electronic lab data, participating in e-prescribing, reporting to public health and sharing care summaries when patients are referred or discharged. The HIE program is also providing "boots on the ground" support to make sure that "data suppliers" with the least capabilities—critical access hospitals, independent labs, and rural pharmacies—are equipped to participate in exchange.

15. According to the American Medical Association, the average cost of an EHR system I estimated to be $30,000 per physician, with an average maintenance cost of between $3,000 and $15,000 per year. At the Subcommittee's hearing, Dr. Kramer testified that this is a significant barrier for a specialty like dermatology where over 40 percent of the practitioners are in private practice or solo practitioners and half are in rural areas. Physicians seeking investment capital are having are having difficulty finding a lender willing to provide them with an unsecured loan. She further testified that some practices may attempt to finance their EHR system purchase with the vendor, but small practices like hers have little or no leverage in negotiating the terms and rates because of a limited market share. What options do small practices like hers have for purchasing EHR systems?

Small practices have several options for purchasing EHR systems. Small practices can work with Regional Extension Centers to develop needs assessments which will determine what system is appropriate for their site. Practices can also work with various financial institutions to get financing for the system. For example, Georgia HITREC has partnered with Flagstar Bank on a program to provide qualified applicants with 100 percent financing of the hardware, software, and installation costs. The provider will have access to 100 percent financing of the hardware, software and installation costs, with the total soft cost not to exceed 30 percent. This program is scheduled to pilot in June 2011 with 20 providers under their group purchasing agreement.

16. Does the Office of the National Coordinator plan to assess the physician participation rates and barrier to participation in Stage 1 of the meaningful use EHR incentive program?

Yes, working with CMS and using other available data we will be able to assess meaningful use participation and how it varies by different eligible provider types. ONC is assessing participation and barriers in several ways. First, ONC will be collecting data through our REC program customer relationship management (CRM) tool regarding performance on each

objective of stage 1 meaningful use. This will help us to assess the appropriateness of each measure's threshold based on empirical data. The CRM tool also will allow for qualitative feedback on specific barriers that providers face in meeting specific meaningful use objectives. Second, we will supplement the CRM feedback with qualitative feedback through our meaningful use community of practice, and detailed conversations with both individual providers and REC leaders and staff in the field. Third, we will analyze data collected by CMS and state Medicaid programs regarding meaningful use attestation. Finally, ONC's formal evaluation program and annual surveys issued through the National Center for Health Statistics and the American Hospital Association will provide important historical analysis to inform this discussion and give ONC a sense of how we are doing over time.

17. Does the Office of the National Coordinator, through the RECs, have plans to reach out to physicians who have not yet adopted EHR to identify barriers to adoption?

Yes, each provider is different and has different needs. One of the key goals of the Regional Extension Centers (REC) program is to address those needs in an individualized manner. This may include an in-depth needs assessment, which identifies the technical assistance for providers who have yet to adopt EHR in their practice or clinic. While each REC has a different business model, each REC is designed to address the needs of providers in their area. To include, education about EHR incentive program and meaningful use, vendor selection and support, EHR implementation, workflow redesign, ensuring EHR systems can communicate with labs and pharmacies, workforce development and achieving meaningful use. Any provider can access the ONC website to find contact information about the REC in their area.

18. If there are additional barriers to successfully participating in the meaningful use of the EHR incentive program, will the Office of the National Coordinator create additional flexibility in the requirements?

The Office of the National Coordinator (ONC) works closely with CMS on the implementation of the EHR Incentive Programs. CMS has the responsibility to measure and evaluate meaningful use requirements.CMS and ONC agree that input from participating providers will be critically important in making future decisions about the structure of the EHR incentive program and public comments will be solicited in Stage 2 and Stage 3 rulemaking. ONC strives to maintain an open and current dialog with a variety of stakeholders via our two Federal advisory committees, the HIT Policy Committee and HIT Standards Committee, as well as other stakeholders.

19. Will the Office of the National Coordinator survey users of EHRs to assess how effective the EHR products are in helping physicians to meet meaningful use requirements?

While CMS has the responsibility to measure and evaluate meaningful use requirements in the EHR incentive programs the Office of the National Coordinator (ONC) supports a national survey of EHR users (among physicians working in office-based practices) that will provide us with information on the effectiveness of EHR products in helping physicians meet meaningful use criteria. The survey specifically asks about the ease and difficulty of using specific functions within EHRs which are critical to meeting meaningful use requirements. The results will help inform us regarding the effectiveness of these products. The survey is being conducted in

partnership with the National Center for Health Statistics (NCHS) and is currently in the field. We expect results to be available at the end of calendar year 2011.

This past year, we conducted surveys in collaboration with the NCHS and the American Hospital Association (AHA) to determine the percentage of eligible physicians and hospitals that intended to apply for meaningful use incentive payments. Thirty-two percent of eligible physicians and 66 percent of eligible hospitals indicated they plan to achieve meaningful use before 2013. To assess how effective systems are in helping physicians achieve meaningful use, starting this year we will have the capability working with CMS to link those attesting for the program with their specific EHR product(s). Additionally, product information is collected on a continual basis from providers participating in our Regional Extension Center Program, and we have solid mechanisms in place to track their progress. In addition, we are conducting a new survey in collaboration with NCHS to assess in a more specific manner the workflow effects of using EHR systems and how those relate to achieving meaningful use.

20. Please provide any surveys HHS has done whether EHRs have helped to reduce medical errors, reduce paperwork, increase efficiency and achieve better health outcomes. Will HHS survey users of EHRs to assess physician views of the efficacy of EHRs?

A comprehensive review of recent health IT literature conducted by authors from ONC published in the March 2011 issue of Health Affairs found 92 percent of the studies reached positive overall conclusions in their assessments of the impact of health IT on key aspects of care including health care quality and efficiency and patient safety and outcomes. Additionally, the authors found providers outside of large integrated care networks, such as the Veterans Administration or Kaiser Permanente, who were early innovators in health IT, are beginning to implement, evaluate, and experience benefits from health IT.

In addition, ONC is currently is fielding a national physician survey that examines provider perception regarding the effects of EHR system. This survey, which is being done in collaboration with the National Centers for Health Statistics (NCHS), will address many of the potential benefits of EHRs from physicians' perspectives. Results from this survey will be available late fall 2011 as data collection is now underway. Existing research indicates the effects of health IT and EHR systems on outcomes, quality of care, and efficiency of care are predominantly positive.

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[i] Miller, et al. The value of electronic health records in 14 Solo or Small Group Practices. Health Affairs, 2005. 24(5).

[ii] De Leon S, Connelly-Flores A, Mostashari F, Shih SC. The business end of health information technology. Can a fully integrated electronic health record increase provider productivity in a large community practice? J Med Pract Manage. 2010 May-Jun;25(6):342-9.

The Computing Technology Industry Association

Testimony Before the

Subcommittee on Healthcare and Technology

House Small Business Committee

The Role of IT Solution Providers in Addressing Health IT Barriers for Small Medical Practices

June 2, 2011

Introduction.

This testimony is submitted on behalf of the Computing Technology Industry Association (CompTIA) representing the interests of over 2,500 IT companies, many of whom are small computer services businesses called Value Added Resellers, also known as "VARs".

We want to thank Chairwoman Ellmers and Members of this Subcommittee for holding this important hearing on health information technology (HIT). This is an extremely critical issue for many CompTIA members that already work with small medical practices.

Small businesses are the backbone of the American economy. According to the Small Business Administration Office of Advocacy, there are approximately 30 million small businesses in the United States, which represent over 99 percent of all employer firms and employ over half of all private sector employees. An even more important statistic for this hearing is the fact that *small businesses hire 40 percent of all high tech workers.*

We want to emphasize to the members of this Subcommittee that small tech providers are a vital and indispensible component of HIT deployment. But unfortunately, the HITECH Act failed to include our industry as a partner in this important undertaking. With this testimony, we would like to provide you with a number of suggestions as to how small IT providers can step up as a full partner in the transition of the health care industry to the use of electronic health records (EHRs).

About CompTIA.

The Computing Technology Industry Association (CompTIA) is the voice of the world's $3 trillion information technology industry. Members include companies at the forefront of innovation along with the channel partners and solution providers they rely on to bring their products to market and the professionals responsible for maximizing the benefits that organizations receive from their technology investments. The promotion of policies that enhance growth and competition within the computing world is central to CompTIA's core functions. Further, CompTIA's mission is to facilitate the development of vendor-neutral standards in e-commerce, customer service, workforce development, and ICT (Information and Communications Technology) workforce certification.

The Issue.

With the passage of the HITECH Act in 2009, Congress set the wheels turning for the broad adoption of EHRs by the health care industry. With a number of exceptions,

this legislation provides incentives to eligible health care professionals under the Medicare EHR Incentive Program of up to $44,000 over a period of five years (the Medicaid EHR Incentive Program provides up to $63,750 over a period of six years). These incentive payments begin this year.

In order to qualify for EHR incentives, each qualifying medical practitioner must adopt the "meaningful use of electronic health records." In addition to this monetary incentive, the legislation includes a penalty in the form of a 1% to 5% reduction in Medicare payments for those practitioners who fail to adopt meaningful use of EHRs by the year 2016.

It is clear that this "carrot and stick" approach will result in a steady migration from paper health records to EHRs over the next few years. However, this transition will not be without massive barriers as it will impose a substantial strain on both small medical practices and their small IT providers, who will be engaged to install the required systems for successful implementation of EHRs.

What are the problems?

Much of our concern can be summarized by comments submitted by CompTIA on May 6, 2011, to the Office of the National Coordinator of Health Information Technology (ONCHIT). These comments were in response to the release by ONCHIT of the "Federal Health IT Strategic Plan: 2011-2015." This plan focuses on implementing key healthcare IT policies over the next five years through coordination between government agencies, the private sector, and the public.

The plan outlines five goals:

- Achieve adoption and information exchange through meaningful use of healthcare IT;
- Improve care, improve population health, and reduce healthcare costs through use of healthcare IT;
- Inspire confidence and trust in healthcare IT;
- Empower individuals with healthcare IT to improve their health and the healthcare system; and
- Achieve rapid learning and technological advancement.

Overall, CompTIA applauds both the general goals of this plan and the fact that the federal government has taken productive steps toward achieving those goals. Nevertheless, in order to realize our shared commitment to better health outcomes, a more efficient delivery of medical services, and a satisfied patient base, CompTIA

believes that small IT service providers must be made more of a partner in achieving these goals.

Education

CompTIA supports the federal government's focus given to universities and colleges to graduate more individuals trained in HIT. Yet, from our experience, very little thought has been given to training existing IT professionals who already have basic IT skills but who need additional help in adding an HIT "bolt-on" to their considerable knowledge and experience in IT. These professionals could be activated very rapidly to help with the transition, but they need some economic assistance – such as a health IT tax credit – to offset some of the costs of this sizeable investment.

Let us be clear, however. While some sort of direct lending to offset education and other costs would be ideal, we understand that we live in times of tight budgets and fiscal discipline. Therefore, we are not now suggesting additional budget outlays. To the contrary, CompTIA is exploring existing tax credit programs that could be temporarily adapted and phased out. In particular, it might make sense to amend the Lifetime Learning Credit and Business Education Tax Deduction so that individuals and IT solution providers could offset some of the expense of earning appropriate certifications and skilling up for the HIT marketplace. This tax credit could provide the necessary incentive to defray the costs for business owners, while ensuring that the workforce is capable of handling the challenge ahead.

Making Technical Assistance More Effective

CompTIA sees wisdom in the federal government's efforts to provide outreach and technical assistance to medical providers by establishing Regional Extension Centers (RECs). However, we suggest that some refinements could make RECs much more effective. An on-going nationwide evaluation by CompTIA has already revealed considerable variance among different REC sites. We suggest that RECs integrate outreach activities with small IT companies that are already serving the IT needs of medical providers in underserved communities. We also suggest that the RECs play a much more robust role in linking small medical professionals to small IT service providers, and vice-versa.

Inspiring Trust & Confidence in Healthcare IT

CompTIA is supportive of the efforts made under the HITECH Act to raise privacy and security standards for personal health information data. CompTIA, in particular, takes note of the safe harbor provision that applies to encrypted data. This is generally consistent with the CompTIA Security Trustmark seal of compliance to validate the security capabilities of IT solution providers. This seal is

compatible with the HITECH Act's requirements to encrypt data containing personal health information.

With that said, we are concerned that the data breach notification requirement within the HITECH Act could present a substantial burden on the small IT service provider that could chill entry into the health IT space. The data breach notification requirement serves as a minimum floor for providing breach notifications in instances where there are "unauthorized uses and disclosures of unsecured personal health information." However, because that provision serves as a floor for regulation, states can impose new and additional requirements that are different and more stringent than the HITECH Act. Under the HITECH Act a data breach notification must be provided within sixty days of a breach, but in states like Massachusetts, a notice of data breach must be provided within 45 days. These are the type of variances that can cause small and medium size businesses millions of dollars in aggregated compliance and legal costs.

CompTIA believes that the HITECH Act should be revised to serve not just as the floor, but also as the ceiling to data notification requirements. One consistent law across the country with an agreed upon notification time period could save small and medium size businesses millions of dollars in reduced compliance and legal costs associated with data breach notification requirements. Such an approach would eliminate uncertainty and confusion as to what the obligation of a business would be in the event of a data breach.

* * * * *

CompTIA fully supports the ONCHIT Plan, but we want to emphasize that small IT service providers must be made more of a partner in achieving these goals. We believe that our suggestions are modest in scope -- but quite large in terms of addressing the concerns of the IT solution provider -- and will go far in making these companies a catalyst for EMR and HIT adoption.

Conclusion.

CompTIA fully supports the migration of the health care industry to electronic health records. However, while the HITECH Act provided a pathway for and assistance to health care professionals to adopt EHRs, there was no similar consideration given to the small IT providers who are being called on to facilitate this transaction. We believe that in order to successfully complete the transition of the health care industry to EHRs, more must be done to recognize IT service providers as an equal partner in this massive undertaking.

national partnership
for women & families
Because actions speak louder than words.

Statement for the Record
Subcommittee on Healthcare and Technology, House Committee on Small Business
Hearing: "Not What the Doctor Ordered: Barriers to Health IT for Small Medical Practices"

Christine Bechtel, Vice President, National Partnership for Women & Families
Member, Health IT Policy Committee

June 2, 2011

The National Partnership for Women & Families is a non-profit, non-partisan consumer organization with 40 years of experience working to make life better for women and families by promoting access to quality health care, fairness in the workplace, and policies that help women and men meet the dual demands of work and family. In my role as Vice President of the National Partnership, I also represent patients and families on the Health IT Policy Committee.

Over the past several years, the National Partnership has led a diverse, non-partisan coalition of consumer, patient and labor organizations — the Consumer Partnership for e-Health (CPeH) — which works on behalf of patients and families to advance patient-centered, consumer-focused health IT. Members of CPeH believe our nation is at a pivotal moment for reforming our health care system with the support of better information.

The unprecedented resources made available by the United States government in the HITECH legislation of 2009[1] and in the health reform law[2] of 2010 create a historic opportunity to transform care so that it is noticeably improved for consumers — the taxpayers who finance these initiatives. There is already evidence that incentives established by HITECH have increased adoption of both basic and fully functional health IT systems.[3] We cannot afford to squander this opportunity.

We recognize, however, that the playing field is not equal when it comes to all providers and hospitals eligible for these incentives. Solo and small practitioners do not have the same level of resources in terms of staffing, technical support, education and training as large practitioners when it comes to health IT adoption.

Helping small medical practices address these barriers is a top priority. There can be no doubt that all patients deserve the benefits that come with the meaningful use of health IT, and small practices deliver the majority of care in this country. We know the path forward will require significant change, much of which has been set in motion with the implementation of HITECH

[1] The American Recovery and Reinvestment Act of 2009.
[2] The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively known as the Affordable Care Act or ACA.
[3] Hsiao, Chun-Ju; Hing, Esther; Socey, Thomas; and Cai, Bill. (2010, December 8). Electronic Medical Record/Electronic Health Record Systems of Office-based Physicians: United States, 2009 and Preliminary 2010 State Estimates. *NCHS Health e-Stat.* Retrieved Feb. 1, 2011, from http://www.cdc.gov/nchs/data/hestat/emr_ehr_09/emr_ehr_09.htm

and the health reform law, and this transformation will be achieved over the course of many years. *But maintaining the status quo is not an option, and consumers will no longer accept it.*

Mr. Chairman, as you hear from health care providers and other stakeholders at the hearing today, I urge you not just to look at the meaningful use program and its requirements for providers. I urge you to look through the eyes of the patients the program is designed to serve, and to examine the wide array of programs established since the passage of HITECH which are designed to provide a holistic framework for success in meaningful health IT adoption and use.

Bringing Health IT to Small Medical Practices

The meaningful use incentives in HITECH, totaling $34 billion, offer an important opportunity for many providers to install health IT systems and use them to improve patient care. But this program does not stand on its own, and its requirements were not created in a vacuum.

First, as we begin to reform our payment and delivery system writ large through innovative models like patient-centered medical homes, accountable care organizations, and bundled payments, these new approaches will require the robust and effective use of health IT. It is not enough to automate current care processes under these models, because they will reward quality and efficiency rather than just volume of care. We must require providers to a better job at care coordination, measuring outcomes of care and engaging patients and families directly. These attributes of a patient-centered system simply cannot be done well or done consistently without health IT. It will be critical that small and solo practices can not only participate in these new models but succeed at them.

Second, HITECH funded the creation of multiple support programs. Perhaps most relevant to today's hearing, the law established the Health Information Technology Extension Program, allocating $677 million to support a nationwide system for providing the kind of training and support small practices need. This includes both a national Health IT Research Center and an array of Regional Extension Centers (RECs) that cover every geographic region of the United States. The research center and the RECs help small and rural providers in adopting EHRs; offering information and guidance to help with EHR implementation; and providing local technical assistance as needed.

Another important resource for small and solo practices is the Office of the National Coordinator for Health IT's (ONC's) Health IT Workforce Development Program. This initiative has begun to train a new workforce that will be able to help providers adopt EHRs. The Community College Consortia to Educate HIT Professionals offers programs that train students in practice workflow and information management as well as technical and software support.

Small and solo practices can also look to the Beacon Community Cooperative Agreement Program and the State Health Information Exchange (HIE) grantees for guidance. The Beacon Program currently funds 17 demonstration communities that will show how health IT can be used to transform local health systems. They will work closely with the RECs to disseminate best practices that other providers can use. The State HIE grantees will develop innovative

approaches to secure information exchange and help providers meet the HIE requirements under meaningful use.

Going forward, we must make sure these programs are funded, administered and implemented effectively – a process we are pleased to see that ONC has already begun and Congress should continue to support.

Role for Consumers

Finally, as small medical practices move forward with implementing health IT, we must consider one additional, and largely untapped, resource in health care: patients and their families. Consumers are enthusiastic about the benefits health IT will afford them, and we, as consumers, stand ready to work with other stakeholders to bring to fruition our vision for a patient-centered, HIT-enabled health care system. In this vision, patients and their families are not passive recipients of care; we seek to refashion the broken health care system as true partners.

While not every individual has the interest, need or capacity to engage deeply in her or his health and health care, we believe a significant subset of individuals representing a range of socio-economic backgrounds and health statuses will. Considering the tremendous growth in the number of people who care for a sick or elderly loved one, greater access to information and electronic tools would meet the direct and daily needs of a burgeoning population that desperately needs information and tools to be more effective caregivers. As more people gain access to information and understand how it can be useful to them, social norms and expectations will shift, and engagement will continue to grow.

It is critical that small practices solicit feedback from patients and caregivers on an ongoing basis as they implement health IT systems – such as through the use of patient and family advisory councils, focus groups, surveys that solicit information about patients' experience of care, and more. Consumers will be able to offer unique insight that will help small (and large) practices overcome numerous challenges, including those related to cultural change, workflow and privacy concerns.

In the end, we understand that, by asking that providers and hospitals implement EHRs and use them in specific ways to improve care, the meaningful use program requires a number of changes to existing provider workflows and cultures. From a consumer perspective, this is exactly what is needed.

We also need to reframe this debate. If we are serious about providing truly patient-centered care, we must flip conventional wisdom on its head and consider the impact that today's health care system has on *patient* workflows and culture. Looking through that lens, there is no doubt that we must keep up the momentum of change in health care, and leverage health IT and the meaningful use incentives as the critical engine that drives us forward.

From Medscape Medical News

E-Prescribing Penalty Could Hit Up to 109,000 Clinicians

Robert Lowes

May 31, 2011 — The Centers for Medicare and Medicaid Services (CMS) is proposing more exemptions to an electronic prescribing requirement that could penalize as many as 109,000 physicians, nurse practitioners, and other prescribers who do not adopt the technology.

The penalty is the flip side of a Medicare program created in 2008 that gives clinicians a bonus if they transmit prescriptions electronically to pharmacies, using approved software. The bonus is 1% in 2011 and 2012 and 0.5% in 2013; it disappears the following year. Meanwhile, clinicians who do not report at least 10 electronic prescriptions on Medicare claims during the first 6 months of 2011 will experience a 1% pay cut in 2012 that grows to 1.5% in 2013 and 2% in 2014 with continued noncompliance.

Not every clinician who treats Medicare patients is eligible to earn the bonus or liable to incur the penalty. For someone to warrant either, his or her e-prescriptions must come during the course of 55 particular medical services (mostly various types of "evaluation and management" services) that are listed by Medicare billing codes. These codes must account for at least 10% of the clinician's Medicare allowed charges. In addition, some clinicians cannot participate because of special billing arrangements they have with the program.

The 2012 penalty will not apply under current regulations to clinicians who:

- lack at least 100 claims involving the 55 billing codes through the first half of 2011,
- lack prescribing privileges, or
- were not licensed practitioners as of June 30, 2011.

In a proposed set of regulations released May 26, CMS estimates that roughly 209,000 clinicians could be subject to the 2012 penalty unless they become successful e-prescribers or qualify for hardship exemptions. Right now, there are only 2 kinds of exemption: if a clinician practices in a rural area without sufficient high-speed Internet access, or if local pharmacies do not receive electronic prescriptions. Because roughly 100,000 clinicians now participate in the e-prescribing incentive program, CMS estimates that as many as 109,000 clinicians could potentially request a hardship exemption to avoid a penalty in 2012.

Harmonizing 2 Incentive Programs

The proposed regulations set forth a number of new hardship exemptions in response to complaints from organized medicine, which views the current rules for the incentive program as confusing and cumbersome.

One of those new exemptions attempts to harmonize the e-prescribing incentive program with its counterpart under Medicare and Medicaid for electronic health records (EHRs), which makes e-prescribing a condition for earning a 6-figure bonus. CMS noted that medical practices may have delayed adopting e-prescribing technology because they intended to participate in the EHR incentive program, which began this year. As a result, a practice that planned to demonstrate "meaningful use" of an EHR during a 90-day period in the second half of 2011 would fail to meet the e-prescribing requirement for the first half of 2011. Accordingly, CMS is proposing to grant an e-prescribing exemption to clinicians who register for the EHR incentive program and adopt certified EHR technology.

Other new hardship exemptions would apply to:

- Clinicians who practice in areas where local, state, or federal laws or regulations impede e-prescribing. A state, for example, may limit or prohibit the electronic transmission of a script through a third-party network, and some clinicians order a large volume of narcotics, which may not be e-prescribed in some states, CMS notes.
- Clinicians who are eligible to write prescriptions but do so infrequently or not at all.
- Clinicians who normally do not write prescriptions for the kind of visits covered by the 55 billing codes. A surgeon, for example, may e-prescribe for his or her patients, but not necessarily in connection with evaluation and management services, which make up most of the pertinent codes.

The proposed rule would extend the deadline for requesting a hardship exemption from next year's e-prescribing penalty from June 1, 2011, to October 1, 2011.

In addition, CMS wants to harmonize the EHR and e-prescribing incentive programs on a technological basis. Under current regulations, e-prescribers must use software programs that CMS deems "qualified."

Under the proposed rule, a clinician could earn an e-prescribing bonus with an EHR system that has been certified by any number of federally appointed vetting organizations.

CMS will be accepting public comments on its proposals, which are to be published in the *Federal Register*, through July 25, 2011. The draft regulations explain several ways to submit comments.

More information on the e-prescribing incentive program, and how to apply for an exemption, is available at the CMS Web site.

Send comments and news tips to news@medscape.net.