

Roll Back the Federal 10-Year Strategic Plan for Health Information Technology

Statement for the Record

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

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Chairman Alexander and members of the committee, thank you for the opportunity to submit written comments about the challenges facing low-income individuals and families in today's economy. I am John R. Graham, a senior fellow at the National Center for Policy Analysis. We are a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

Health Information Technology (HIT) includes a wide range of products, technologies and services, such as electronic health records (EHRs), mobile and telehealth technology, cloud-based services, medical devices, and remote monitoring devices, assistive technologies and sensors.¹

At the end of 2014, the federal Office of the National Coordinator of Health Information Technology (ONC) released a proposed 10-year strategic plan for the federal role in HIT, and invited public comments.² This is the NCPA's response to that invitation and we offer it to the Committee for your review during this important hearing on health information technology.

President George W. Bush launched ONC via executive order in 2004. At the time, its mission was simply "coordination." In 2009, the ONC was more solidly established in legislation signed by President Obama. Through the HITECH Act, the federal government became HIT's chief financier, certifier and regulator. The Centers for Medicare and Medicaid Services (CMS) was given a 5-year budget of \$30 billion to disburse as incentives to hospitals, physicians' offices and other health facilities to encourage installation of EHRs. ONC was given the power to certify the EHRs that qualify providers for the incentive payments. Thus, the federal government has exerted significant control over the evolution of HIT.

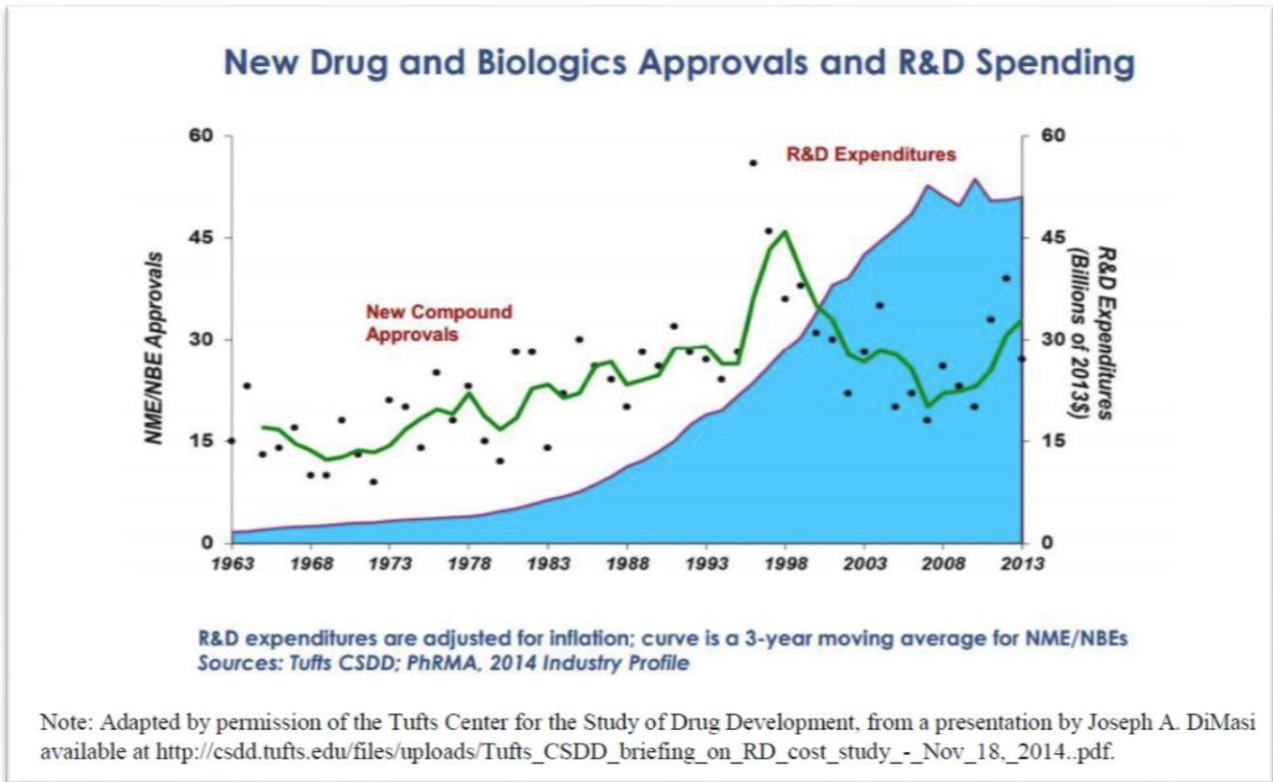
The attempt to get medical providers to adopt EHRs has proven expensive, unproductive and potentially harmful, leading to the conclusion that the federal government should play a minimal role in guiding HIT over the next decade.

Health Information Technology Is Important for Our Health System

Health Information Technology (HIT) is on the cusp of transforming American health care. Two recent reports quantify how much capital is invested in new HIT ventures. StartUp Health, a New York-based accelerator, and Rock Health, a San Francisco-based accelerator and seed fund, independently reported funding for new HIT ventures in the United States doubled in 2014:

- Looking only at investments worth at least \$2 million, Rock Health estimates that \$4.1 billion of new capital was invested in HIT, up from less than \$1 billion in 2011.³
- StartUp Health, which captured smaller investments, estimates that \$6.5 billion in new capital was invested in HIT in 2014, up from \$1.2 billion in 2010.⁴ [See the figure on the next page.]

The new strategic plan is an update of the original five-year plan issued when the CMS and ONC began the EHR incentive program in 2011.⁵ The federal government's very straightforward vision with respect to health information technology states, "Health information is accessible



when and where it is needed to improve and protect people’s health and well-being.” Its equally clear-cut mission is to “improve health, health care and reduce costs through the use of information and technology.”⁶

The plan defines five goals: expand adoption of HIT; advance science and interoperable health information; strengthen health care delivery; advance the health and well-being of individuals and communities; and advance research, scientific knowledge and innovation. Objectives, outcomes and strategies are proposed with 3-year or 6-year timeframes.

Nothing is objectionable about any of these goals. Of more concern is the scope of “coordination” of the federal government’s role in the HIT plan: The Federal Health IT Advisory Council comprises 35 federal agencies, including the Federal Communications Commission (FCC) and the National Aeronautics and Space Administration (NASA)!

While it would be absurd to recommend a complete federal withdrawal from coordinating HIT, the experience of the ONC’s first five years indicates federal power and influence over HIT should be significantly reduced. This can be demonstrated by closely examining the EHR incentive program.

Federal Intervention in Electronic Health Records

In 2009, the Congressional Budget Office (CBO) estimated the EHR incentives would cost \$30 billion through 2019, of which \$23.9 billion would be spent through 2014.⁷ The cash flows directly from the federal Medicare program and state Medicaid programs. Despite the squeeze in EHR incentive payments due to the budget sequester of 2013, \$24.8 billion was spent through

July 2014.⁸ While EHR incentives have only slightly exceeded the budgeted amount, results nevertheless suggest this spending has prevented the natural adoption of EHRs, and may have even lowered the quality of care.

The CBO estimated the incentives would encourage about 70 percent of hospitals and 90 percent of physicians to adopt EHRs by 2019; and, without the incentives, those adoption rates would only reach about 45 percent for hospitals and about 65 percent for physicians.⁹

It is unlikely these targets will be achieved. According to an ONC report:

- In 2013, 59 percent of hospitals and 48 percent of physicians had at least a basic EHR system, increasing 47 percentage points and 26 percentage points, respectively, since 2009, the year Congress enacted the HITECH Act.
- Moreover, there was widespread participation among eligible hospitals and professionals; as of June 2014, 75 percent of the nation's eligible professionals and 92 percent of eligible hospitals had received payments under the CMS EHR incentive programs.¹⁰

But the CMS only has about \$5 billion of its \$30 billion budget left to spend. And many providers appear to have received incentive payments but are not fulfilling their obligations.

Two flaws in the program that cause physicians to drop out have been widely identified. First, the EHRs are harmful to health professionals' productivity. Second, they are not "interoperable," which means that different EHRs do not speak to each other.

The first problem is exemplified by the experience of a physician, Mark Sklar:

"The push to use electronic medical records has had more than financial costs.

"Yet to avoid future financial penalties from Medicare, I must demonstrate 'meaningful use' of the electronic record. This involves documenting that I covered a checklist of items during the office visit, so I spend 90 minutes each day entering mostly meaningless data. This is time better spent calling patients to answer questions or keeping updated with the medical literature.

"My practice quickly adopted the new Medicare requirements for electronically prescribing medications. Yet patients often do not want their prescription sent electronically.

"If I don't electronically prescribe for a certain number of Medicare patients, I am penalized with a decrease in reimbursement that can rise to a maximum of 5%. Patients should have a choice in how their prescriptions are delivered, and physicians shouldn't be penalized for how the patients choose."¹¹

Perhaps the most influential report on HIT was issued last year by an independent scientific group called JASON, which confirmed Sklar's frustration. Referring to the rapid transition from paper to electronic health records, the report concluded "...there are questions about whether that transition will actually improve the quality of life, in either a medical or economic sense."¹²

"Meaningful Use" of ONC-certified EHRs triggers the incentive payments, but it is a moving bureaucratic target. There are three stages of Meaningful Use:

- Stage 1 is easy, demanding only 30 percent of patient records be entered by computerized order entry.
- Stage 2 requires interoperability, and was originally supposed to be achieved by 2013; but the deadline has been pushed back to 2016.¹³
- The delay in Stage 2 will push Stage 3, for which the rule is not yet finalized, into 2017.

There is a difference between getting paid and actually “attesting” to meaningful use. At a September 2014 meeting of the Health IT Policy Committee, the administration disclosed that only 3,154 eligible professionals (doctors, dentists and so forth) had attested to Stage 2 to get their bounties. Only 143 hospitals had attested.¹⁴ Marc Probst, Intermountain Healthcare chief information officer, who attended the meeting, was disappointed: “The numbers are very low, particularly for Stage 2 attestation. I mean they [sic] are like 4 percent of [providers] that should be currently going for Stage 2.”¹⁵

However, this failure was anticipated. Only 15 percent of professionals had previously reported on an optional Stage 1 measure: to provide a summary of care document at each care transition or referral.¹⁶ Because Stage 2 mandates this document, more providers should have reported it in Stage 1 if they had planned to also attest for Stage 2.

Indeed, a March 2014 Government Accountability (GAO) report found (within the 36 states that reported) 61 percent of professionals and 36 percent of hospitals participating in the Medicaid EHR program in 2011 did not continue in 2012. Sixteen percent of professionals and 10 percent of hospitals participating in the Medicare EHR program in 2011 did not continue in 2012.¹⁷

Doctors are learning the incentive payments do not cover the true cost of installing EHRs, which includes a loss of productivity. According to a January 2015 survey of almost 2,000 physicians conducted by SERMO (an online community of physicians), 55 percent of physicians said they would not attest to Stage 2 in 2015.¹⁸

Physicians balk at Stage 2 because it has a high hurdle for interoperability. According to the final rule published in September 2012, requirements include “the expectation that providers will electronically transmit patient care summaries with each other and with the patient to support transitions in care. Increasingly robust expectations for health information exchange in Stage 2 and Stage 3 would support the goal that information follows the patient.”¹⁹

Despite the delay in Stages 2 and 3 deadlines, providers are still complaining that the requirements are too demanding. According to Russell Branzell, president and CEO of the College of Healthcare Information Management Executives: “Now the very future of Meaningful Use is in question.”²⁰ The JASON report concluded, “These interoperability issues need to be solved going forward, or else the entire health data infrastructure will be crippled.”²¹ Further, JASON continued: “The criteria for Stage 1 and Stage 2 Meaningful Use, while surpassing the 2013 goals set forth by HHS for EHR adoption, fall short of achieving meaningful use in any practical sense.”²²

According to an August 2014 analysis, only 10 percent of ambulatory practices and 30 percent of hospitals were participating in operational health information exchange efforts.”²³ Indeed, evidence from congressional investigations suggests meaningful use bounties have encouraged the adoption of EHRs that are *deliberately closed* to exchange with other parties.²⁴

In defense of the EHR incentives program, in October 2014 CMS reported that since 2008, less than half of hospitals electronically shared clinical care summaries (42 percent) and medication lists (37 percent) with any providers outside of their system, a 68 percent increase for clinical care summaries and a 76 percent increase for medication lists.²⁵ But read that carefully: “Summaries” and “lists” can include e-mailing a text document as an attachment, which is not an accurate use of HIT.

A 2014 report for the RAND Corporation also concluded the federal money was invested poorly:

“Unfortunately, the rules that the U.S. Department of Health and Human Services (HHS) issued to guide implementation of HITECH watered down the requirement for connectivity. The practical effect was to promote adoption of existing platforms, rather than encourage the development of interconnected systems. Although large vendors and many health care systems welcomed this decision, it was criticized by others.

By subsidizing “where the industry is” rather than where it needed to go, HHS rule-makers allowed hospitals and health care providers to use billions in federal subsidies to purchase EHRs that did not have the level of connectivity envisioned by the authors of the HITECH act.”²⁶

This remarkable report furthers a journey by RAND scholars. In 2005, RAND estimated the uptake of EHRs would lead to savings of \$81 billion annually, an estimate it abandoned in 2013.²⁷

Unfortunately for many providers, what Uncle Sam giveth, Uncle Sam taketh away. This year, CMS will begin penalizing providers who do not follow the plan. Last December, CMS announced it would dock 1 percent of Medicare payments to 257,000 physicians for not using EHRs “meaningfully” and another 1 percent from 28,000 providers for not prescribing electronically. In October, CMS announced fines of 1 percent for about 200 hospitals.²⁸

The American Medical Association (AMA), which endorsed the HITECH Act in 2009, declared it was “appalled” that over half of eligible professionals will be fined for failing to meet meaningful use targets in 2015; then, it stated, “The overlapping and often conflicting patchwork of laws and regulations must be fixed and aligned to ensure physicians are able to move to innovative payment and delivery models that could improve the quality of care.”²⁹

Because most health care providers appear to have installed EHRs for the purpose of receiving a government payment, it is not surprising to learn the EHR industry has not been as vibrant as it could have been if adoption had been driven by market demand. In 2012, only five EHR vendors accounted for over 50 percent of the market, leading an expert to comment, “There is concern that the EHR market, itself, represents a barrier to innovation.”³⁰ According to the JASON report, “Current approaches for structuring EHRs and achieving interoperability have largely failed to open up new opportunities for entrepreneurship...”³¹

The Federal Government and the Future of Health Information Technology

While ONC is the hub of the wheel of federal HIT efforts, too many parties compete for the effort to be coordinated centrally. According to another JASON report:

“There are at least 50 separate agencies charged with health care responsibilities in the federal government. There are also the 50 states, each running its own health care and public health systems. There are tens of thousands of private-sector health care providers and enterprises, both large and small, delivering medical services. HHS might be regarded as the closest approximation to a central authority for health care issues in the US government, but its jurisdiction is limited.”³²

Its poor record at financing, certifying and regulating EHRs leads to the conclusion that the federal government should — as much as possible — keep out of the way.

The importance of this laissez-faire approach is especially high now, as the integration of patients’ digital data from multiple sources is the next stage of HIT development. The JASON report also recognizes this:

- As health-care teams continue to grow, with nurse practitioners and other allied health professionals taking more responsibility for patient care, HIT will influence how the teams work together.³³
- To optimize the data in EHRs, they will have to integrate data from personal health records (PHRs), which are controlled by patients.³⁴
- “Above all,” says JASON, “it will begin to shift control from a small number of software vendors to a software ecosystem with a diversity of products and ‘apps,’ focused on the patient, and enabling health care providers to partner with patients in data sharing.”³⁵

For this vision to succeed, the federal government must resist the temptation to play the central role, as it has done with EHRs. Interoperability across devices requires not only a common mark-up language (html) but Application Program Interfaces (APIs) allowing third-party developers to link the systems. APIs are the very programs that have made smartphones so powerful within the last few years — absent government subsidy or certification. JASON recognizes that APIs are working for mobile health, but lacking for EHRs.³⁶ The federal government should step aside so that HIT can evolve the way smartphones have, and allow entrepreneurial EHR vendors a fair shot at displacing the dominant incumbents.

Indeed, movement in this direction has begun, perhaps influenced by the fact that CMS is running out of EHR incentive payments. The JASON report described an open architecture for HIT in the next decade, and elements of it have been taken up by vendors with old EHR systems.³⁷

Conclusion

Some have argued that CMS needs more money than was budgeted in 2009 in order to achieve the goal of HIT interoperability. Congressional proposals would attach funding to “must pass” legislation that will ensure physicians do not get a huge cut in their Medicare fees.³⁸

These proposals should be avoided, so that the rest of our emerging HIT ecosystem does not suffer the same fate as EHRs have over the past five years. The flood of government money into an emerging EHR landscape perverted the natural adoption of EHRs and has led to an installed base of EHRs that are not as effective as they would have been had the government not interfered. As HIT expands in unpredictable directions, the federal government should exert a humble and light regulatory touch; and refrain from the temptation to spend more money to encourage the types of technologies preferred by the government, instead of patients and providers. The billions of dollars in capital being invested in HIT must be allowed to find their own course to success.

Thank you for the opportunity to submit these written comments.

Notes

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