July 23, 2013

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Room 445-G
Washington, DC 20201

Dear Secretary Sebelius:

On behalf of our members, who include the vast majority of health care providers seeking to adopt and meaningfully use electronic health records (EHRs) to improve the efficiency and quality of care, the American Hospital Association (AHA) and the American Medical Association (AMA) appreciate the opportunity to share with you our concerns with certain aspects of the Meaningful Use Program. **Our members share the administration's commitment to the widespread adoption of EHRs; however, we believe that the best way to move the program forward and ensure that no providers, particularly small and rural ones, are left behind is to realign the Meaningful Use Program's current requirements to ensure a safe, orderly transition to Stage 2.**

We appreciate the Department of Health and Human Services' (HHS) decision to extend Meaningful Use Stage 1 through 2013. Physicians and hospitals have made significant investments in health information technology (IT), which is evidenced by the increasing numbers of providers who are using EHRs and attesting to Meaningful Use. We also share the administration's commitment that no providers – or the patients they serve – are left behind as we proceed to Stage 2. However, our members, and the vendors they work with, report growing concerns that the rapidly approaching start date for Stage 2 is on a trajectory that will not provide enough time or adequate flexibility for a safe and orderly transition unless certain changes are made.

Our concerns and recommendations for a safe and orderly transition to Stage 2 of Meaningful Use are detailed below:

TIGHT REGULATORY TIMELINES JEOPARDIZE VENDOR READINESS AND PROVIDER IMPLEMENTATION

We are concerned that the vendor community is not ready for the challenge of moving to Stage 2. At this time, we are less than three months away from the start of Meaningful Use Stage 2. For hospitals, Stage 2 begins on October 1, 2013, the first day of federal fiscal year (FY) 2014. For physicians, the start is January 1, 2014, the beginning of the calendar year (CY). Current policy requires all hospitals and physicians to upgrade to the 2014 Edition EHR during FY/CY 2014, whether they are beginning participation in the Meaningful Use Program in 2014 or are among the trailblazers who entered the program when it first began more than three years ago. This means that the EHR vendors will need to support more than 500,000 hospitals and physicians on an aggressive timeline.

As of July 17, the official federal list of certified vendor products shows only nine complete 2014 Edition certified EHRs for the inpatient setting, produced by only six vendors. By comparison, the list shows 313 complete 2011 Edition certified inpatient EHRs. On the ambulatory side, only 11 complete 2014 Edition certified EHRs are listed, while about 1,300 were certified for 2011.

We also have heard from our members that vendors are delaying the delivery of updates, and providers who have not yet installed an EHR will be at the end of the queue and may not receive delivery for another 12 to 18 months. Of course, receiving an upgrade is only the first step in making the transition to the 2014 Edition and meeting the Meaningful Use requirements. It is reasonable to expect that a provider will need up to a year after receiving a technology upgrade to make all of the necessary changes to meet the program requirements.

The compressed timeline puts providers in a position of rushing to implement, creating conditions that prevent them from optimizing use of the systems and possibly introducing risks to patient safety. The mandate to simultaneously upgrade 500,000 plus providers to the 2014 Edition unnecessarily creates market pressures that will stretch vendor technical and workforce resources and drive up technology and consulting prices. These time constraints are exacerbated by the need for health care providers to meet coinciding federal requirements, such as the transition to ICD-10 by October 1, 2014. **Furthermore, some providers are reporting significant challenges with the usability of their current certified EHRs, a situation that will be exacerbated as vendors channel their efforts to managing a nation-wide transition to the 2014 Edition.**

GREATER FLEXIBILITY WILL ENHANCE PROGRAM SUCCESS AND ACCOMMODATE SMALL AND RURAL PROVIDERS

We are concerned that the current timelines will exacerbate the digital divide. Studies have repeatedly shown that small and rural providers do not have the same resources as larger ones to adopt health IT. A series of recently published articles in *Health Affairs* found "large urban

hospitals continue to outpace rural and nonteaching hospitals in adopting EHR systems." The same study found that only 5 percent of hospitals could meet a proxy for Stage 2. On the ambulatory side, researchers found higher EHR adoption rates among "physicians in practices with eleven or more physicians, in practices owned by a hospital or an academic medical center, and in counties where less than 15 percent of the population was in poverty." In order to accommodate smaller and rural providers who will be at the end of vendor queues, and to reduce the likelihood for a growing "digital divide" among providers, additional flexibility is needed in the transition to the 2014 Edition EHR and Stage 2. We believe such flexibility in meeting Stage 2 requirements will allow more providers to succeed, and keep the program moving forward. In health care environments, where systems must be available around the clock every day of the year, implementing new technology functionalities requires extra caution and time.

In addition to the timing issues discussed above, the Stage 2 rules are tremendously complex and include entirely new requirements – such as sending summary of care documents – or expand on requirements that were a significant challenge in Stage 1 – such as public health reporting or reporting electronic quality measures. Many of the objectives make provider performance contingent on the actions of others (such as health information exchanges, patients and public health departments), and assume a level of interoperability and information exchange infrastructure that is still in its infancy. Moreover, Stage 2 requires adoption and use of many new and unfamiliar standards, such as SNOMED for patient problems. Finally, many of the objectives bundle together multiple requirements, such as using order-entry systems for three types of orders – medications, laboratory tests and radiology tests.

Given this complexity and level of difficulty, a program with an "all or nothing approach" – in which failure to meet any individual part of an objective, or missing a threshold by a small amount, leads to overall failure in meeting Meaningful Use – is overly burdensome. This seems especially true given that any provider failing to successfully transition to Stage 2 will not only miss an incentive payment but also receive a future payment penalty. Providers who fail to enter the program for the first time in 2014 will also receive future payment penalties.

RECOMMENDATIONS

With these concerns in mind, we respectfully submit the following recommendations for changes to the program for all providers. We believe all of them can be accomplished without statutory change:

1. **Allow providers at Stage 1 to meet the requirements using either the 2011 certified Edition EHR, or the 2014 certified Edition EHR.** This change will allow more time for vendors to complete their upgrades, thereby allowing advanced providers to move ahead to Stage 2, while holding harmless those remaining or entering the program at Stage 1.

2. **Establish a 90-day reporting period for the first year of each new stage of Meaningful Use for all providers, similar to what was done for Stage 1.** This change will allow upgrades to be spread out over time, rather than being clustered on certain dates.

3. **Offer greater flexibility to providers in meeting Stage 2 to ameliorate the "all or nothing" problem, and recognize that the level of change in Stage 2 will take time to accomplish.**

4. **Extend each stage of Meaningful Use to no fewer than three years for all providers.** This change recognizes that vendors need time to develop usable and safe upgrades, and providers need time to implement systems and optimize their use before undertaking yet another upgrade.

We believe that these policy adjustments would provide increased flexibility to achieve our shared goals. Time is of the essence in addressing these concerns and ensuring that we can, in fact, achieve a safe, orderly transition to Stage 2 that leaves no one behind.

Thank you in advance for your consideration of these issues. In addition, each of our organizations has concerns distinct to the inpatient and ambulatory settings that will be shared separately. We welcome the chance to discuss these recommendations in greater depth. If you have any questions, please contact Chantal Worzala, AHA Director of Policy, at cworzala@aha.org, or Mari Savickis, AMA's Assistant Director of Federal Affairs, at mari.savickis@ama-assn.org.

Sincerely,

Richard J. Umbdenstock
President and CEO
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