



**American Hospital
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February 8, 2016

The Honorable Lamar Alexander
Chairman, Committee on
Health, Education, Labor and Pensions
United State Senate
Washington, DC 20510

The Honorable Patty Murray
Ranking Member, Committee on
Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members of the American Hospital Association (AHA), I am writing regarding the Committee's draft legislation addressing health information technology (IT) and electronic health records (EHRs). We understand this is part of the Committee's larger innovation agenda and commend the Committee for its overall effort to find better ways to accelerate the discovery of new cures and improve biomedical research.

The AHA appreciates the attention and focus you have brought to the important topics of EHRs and interoperability. We also appreciate the acknowledgement of the burdens facing providers and the focus on the federal EHR certification program. However, we have concerns regarding the problematic information blocking provisions included in the draft. In addition, we recommend additional focus on testing of health IT and would like to ensure that the private sector is fully engaged in efforts to create a governance framework for information sharing.

The AHA strongly supports the creation of an efficient and effective infrastructure for health information exchange that facilitates the delivery of high-quality, patient-centered care across health care settings. America's hospitals and health systems are actively engaged in building their IT systems and view information exchange as vital to care improvement and consumer engagement, as well as to successful implementation of new models of care.

Hospitals and physicians have made great strides in implementing EHRs over the past five years. Indeed, the most recent AHA survey data shows that, by 2014, 75 percent of hospitals had at least a basic EHR in place – almost five times the share in 2010. Furthermore, in 2013, only 10.4 percent of hospitals had established ways for consumers to access their health information, but by 2014, 64.3 percent had done so. That is more than a six-fold increase in one year, with



additional gains expected in 2015 and 2016.¹ To make this progress, hospitals collectively invested hundreds of billions of dollars in their information systems between 2010 and 2014.

Information Blocking (Sec. 4). We strongly support the Committee's inclusion of separate definitions of information blocking for health IT developers and health care providers, and the focus on care provision in the provider definition. Providers have an obligation to share health information needed for care and to engage patients, and hospitals and health systems are working to build systems for that purpose. Despite the shared goal of having health information follow the patient to inform care, hospitals and health systems report that many EHRs do not easily share information and providers do not universally have access to efficient exchange networks and other infrastructure. In addition, the cost and complexity of the many interfaces needed to connect systems today are simply not sustainable. All providers also must work within the constraints of existing state and federal privacy rules.

For those reasons, we have concerns that the enforcement provisions risk unfairly penalizing providers as engaging in information blocking when the core issue is technical or operational. In general, the enforcement provisions in Sec. 4 strike the appropriate balance of using existing authorities to establish a deterrent. However, we are concerned about the inclusion of a separate and contradictory set of circumstances where providers could be unfairly subject to penalties for information blocking. Specifically, we are concerned that providers could be considered to engage in information blocking if they refuse to "exchange health information with an individual or entity using certified health information technology that is technically capable of trusted exchange." This broad statement does not reflect the purpose of the exchange or the technical and operational challenges of sharing information. We feel it is unfair to penalize providers when the technical infrastructure needed to effectively and efficiently share information is either not available or only available at an unreasonable cost or with undue effort. We recommend adding legislative language to focus on mechanisms to ensure the availability of efficient and effective trusted exchange in practice, and particularly robust testing of products.

Interoperability (Sec. 5). We appreciate the Committee's focus on interoperability. The AHA recently released a [report](#) of its Interoperability Advisory Group, which concluded progress will require collaborative work across the public and private sectors and identified specific actions different stakeholders should take to move forward. A key barrier to achieving interoperability is the lack of consensus on which standards to use and how to use them. Standards that are used consistently by all allow data to flow between computers and keep the same meaning for both the person sending it and the person receiving it. While many standards have been included in the meaningful use program, many of them are immature. As a result, providers are using products that have unique system configurations and implementation across the spectrum.

Identification of standards is essential, but not sufficient to achieve interoperability. Federal support of widely available conformance testing would improve the ability of vendors and providers to create solutions that work. It is only by thorough and widely available testing that

¹ Adler-Milstein, et al. Electronic Health Record Adoption In US Hospitals: Progress Continues, But Challenges Persist. Health Affairs. Nov 2015.

true interoperability can be achieved. **We urge the Committee to direct the National Coordinator to work with the National Institute of Standards and Technology on evaluating the maturity of nationally recognized standards and implementation specifications and creating opportunities for robust testing by standards organizations, technology developers and end-users.**

As reflected in the draft, sharing health information requires access to networks for exchange. The text tasks the National Coordinator with convening “public-private and public-public partnerships to build consensus and develop a trusted exchange framework, including a common agreement among health information networks nationally,” including rules of the road, operational policies and methods for ensuring compliance. **The AHA urges the Committee to ensure that the private sector plays a driving role in establishing the trusted framework for exchange to ensure timely action and capture recent innovations.**

To be truly interoperable, EHRs must be able to successfully and accurately identify individual patients. We support the inclusion of a study on patient matching (Sec. 6) to bring us closer to that goal and urge the Committee to consider accelerating the timeline for the report from two years to one year.

Increasing Transparency for EHRs (Sec. 3). The AHA supports improvements to the federal EHR certification process that would provide enhanced transparency to providers, such as the creation of a rating system included within the draft. Currently, the certified EHRs hospitals are required to purchase under the EHR Incentive Programs do not meet the mark when it comes to sharing information to improve care and support new models of care.

The AHA supports providing a hardship exception from the Meaningful Use program for providers using products that are decertified by National Coordinator. **However, we urge the Committee to consider expanding the hardship exception to those providers whose products receive a one-star rating. We also support allowing the exception to continue for longer than one year.** Migrating to a new EHR system and ensuring it is running smoothly is not a simple or quick process and may require additional time. Finally, we would encourage the Committee to re-evaluate the timelines laid out in the draft for establishing transparency mechanisms and consider accelerating them.

Reducing Burden (Sec. 2). We appreciate the Committee’s willingness to look at ways to assist hospitals in improving the quality of care for patients by reducing provider burden. Hospitals must adhere to requirements from a multitude of federal programs, and we support convening public and private stakeholders to develop goals, a strategy and recommendations to minimize the burden on providers. We encourage the Committee to consider calling for report to Congress from the Department of Health and Human Services within in a specific timeframe or direct the department to release proposed rules to make needed regulatory changes.

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Thank you in advance for your consideration of these issues. If you have any questions, please contact Kristina Weger, senior associate director for federal relations, at (202) 626-2369 or kweger@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President