

**STATEMENT OF THE
AMERICAN COLLEGE OF PHYSICIANS
TO THE HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH**

Hearing on "Health Information Technology"

July 27, 2005

The American College of Physicians (ACP) -- representing 119,000 physicians and medical students -- is the largest medical specialty society and the second largest medical organization in the United States. Internists provide care for more Medicare patients than any other medical specialty. Of our members involved in direct patient care after training, 50 percent are in practices of 5 or fewer physicians and 66 percent are in practices of 10 or fewer. We congratulate Subcommittee Chairman Nancy Johnson and Ranking Member Pete Stark for recognizing the importance of moving toward an interoperable health information technology infrastructure and the crucial role the federal government has in assisting the health care industry acquire and utilize information technology. Thank you for holding this important hearing on congressional involvement in speeding the adoption of health information technology.

Background

In the Institute of Medicine's (IOM) 2001 Report, "*Crossing the Quality Chasm – A New Health System for the 21st Century*," the authors describe the growing disparity between society's willingness to embrace the advantages of information technology in many aspects of everyday life, with the exception of health care. The IOM report cautions, however, "In the absence of a national commitment and financial support to a build a national health information infrastructure...the progress of quality improvement will be painfully slow."¹ Since that time, numerous studies and other policy experts agree that the full adoption and utilization of health information technology (HIT) can revolutionize health care delivery by improving quality of care and reducing high medical costs.

Meanwhile, Congress and the Administration have taken some initial steps to advance the adoption of an interoperable health information infrastructure model. The 2003 Medicare Modernization Act anointed the Commission for Systematic Interoperability to take the

¹ Institute of Medicine, *Crossing the Quality Chasm – A New Health System for the 21st Century*, March 2001, and U.S. Department of Human Services, *Information for Health: A Strategy for Building the National Health Information Infrastructure*, Report and Recommendations from the National Committee on Vital and Health Statistics, November 15, 2001.

lead in developing a strategy for the adoption of uniform national standards. In the 109th Congress, several bills have been introduced to mold the framework for adopting HIT infrastructure.

President George W. Bush also seized on the opportunity to further HIT adoption. In his January 2004 State of the Union address, Bush first described the benefits that information technology will bring to the health care sector: “By computerizing health records, we can avoid dangerous medical mistakes, reduce costs and improve care.”² The President backed up this support by proposing additional funding for federal HIT initiatives in his FY 2005 and FY 2006 Budgets.

More significantly, however, was the April 2004 announcement by the President calling for the widespread adoption of interoperable electronic health records within the next decade. To oversee this bold, new, ten-year initiative, the President announced the creation of the Office of National Coordinator for Health Information Technology (ONCHIT), and named its first Director, Dr. David J. Brailer. Subsequently, ONCHIT devised a 10-year funding strategy for policymakers to consider in speeding HIT adoption nationwide. According to ONCHIT’s “Framework for Strategic Action,” Congress should consider several funding options, including additional Medicare reimbursement as well as the use of loans, tax credits, and grants. It also should consider the easing of fraud and abuse laws to allow the sharing of electronic hardware.

ACP strongly supports the Congress and the Administration in these initiatives to speed the adoption of uniform standards for health information technology (HIT). The College is committed to providing practicing internists with practical tools to help them improve quality. ACP’s Physicians Information and Education Resource (PIER) provides ACP members—at no cost to them—with access to “actionable” evidence based guidelines at the point of care for over 300 clinical modules. PIER has also been incorporated into several electronic health record systems. It is currently in the process of aligning its evidence-based content to support a starter set of measures selected by the Ambulatory Care Quality Alliance (AQA). PIER is also creating paper order sets that imbed such quality measures so that physicians who have not made the transition to electronic health records could still utilize PIER content to support their participation in performance measurement initiatives.

ACP’s Practice Management Center has developed resources to help internists in the decision-making process on electronic health records and is leading an initiative to provide internists with tools and best practices to help them redesign their office processes to improve health care quality.

But without sufficient financial assistance from the federal government to incentivize providers to purchase the full range of HIT, particularly those in small physician practices, we will be unable to achieve a smooth transition into a fully-integrated HIT society. **We believe it is absolutely essential for Congress to begin to immediately**

² Bush, George W., State of the Union, Washington, DC, January 20, 2004.

fund initiatives to adopt uniform national standards, and to fully fund the pilot testing of HIT integration into all health care sectors.

The Benefits of Interoperable Health Information Technology

Policymakers agree that the universal utilization of interoperable HIT can revolutionize health care delivery by putting real-time clinically relevant patient health information and up-to-date evidence-based clinical decision support tools into the hands of providers. Adoption of HIT at all levels of health care will lead to the improvement of health care quality and reduce the high costs for individuals with complex health problems, particularly for those Medicare patients with multiple costly chronic conditions.

Investment in the adoption of HIT is expected to result in significant return savings. **The Department of Health and Human Services (HHS) and ONCHIT both agree that savings from a universal interoperable HIT infrastructure could achieve between \$140 billion to \$170 billion per year, close to 10 percent of total U.S. health spending.** They note the majority of these savings would be achieved by reducing duplicative care, lowering health care administrative costs, and avoiding costly medical errors. Independent studies also confirm substantial annual savings as well.³

The savings could even be more substantial when the adoption of HIT is coupled with value-based purchasing programs (also known as “pay-for-performance”), now under consideration by key congressional committees. Substantial savings in the Medicare Part A Trust Fund could be captured by preventing unnecessary hospitalizations caused by complications, needless duplications of medical tests and procedures, and the lowering of health care administrative costs. Unfortunately for small physician practices considering whether to make a significant investment in converting their practice to a fully-integrated HIT system, the cost-benefit analysis of making the initial purchase currently favors the public and private payer over the health care provider.

Costs of Acquiring Health Information Technology

The single biggest barrier to achieving fully interoperable HIT across the nation is the substantial cost in acquiring the necessary technology. This obstacle is especially acute for physicians practicing in small office settings, where three-fourths of all Medicare recipients receive outpatient care.⁴ An additional related barrier is that public and private payers, not the physicians, will realize the savings from physician investment in acquiring the necessary HIT (i.e., electronic health records, electronic prescribing, clinical decision support tools, etc).

³ Walker, Jan; Pan, Eric et al., Health Affairs, “The Value of Health Care Information Exchange and Interoperability,” January 2005. “Full standardized health care information exchange and interoperability could yield a net value of \$77.8 billion per year once fully implemented.”

⁴ Center for Studying Health System Change, “Most Medicare Outpatient Visits Are to Physicians With Limited Clinical Information Technology,” July 2005.

The initial start-up costs for the purchase of a fully interoperable HIT system can be substantial. **Depending on the size of the practice and its applications, acquisition costs on average range from \$16,000 to \$36,000.**⁵ (The Harvard Center for Information Technology Leadership estimates HIT systems cost about \$29,000 per physician). The ongoing costs associated with training, maintenance, and system support of the HIT system make these estimates substantially higher over the lifetime of the practice.

Unfortunately, the savings from interoperable HIT will largely go unrecognized for physicians making the investment to convert their practices. In fact, it's more likely the majority of the savings from physician investment will be recognized by payers and patients – through a reduction in duplicative care, the lowering health care administrative costs leading to lower health insurance rates, and avoiding costly medical errors – not to the providers that pay the initial and ongoing implementation costs. **ACP strongly believes that physicians' collective and individual contributions must be recognized in order to achieve Medicare and Medicaid savings through HIT adoption. Current reimbursement policies should allow for individual physicians to share in the system-wide savings that are attributable to their participating in HIT and other quality improvement programs.**

While the College and the physician community recognize the great potential for improving the overall quality of care that HIT brings, the majority of small physician practices cannot afford to expend the necessary capital to make the initial investment. For physicians dealing with a multitude of financial issues – ranging from low reimbursement under Medicare and Medicaid, declining fees from managed care, the rising costs of medical malpractice insurance, and the cost of compliance under increasing state and federal regulation – the majority are not in any financial position to make the initial \$16,000 to \$36,000 investment.

The reality of HIT underinvestment by the typical physician practice is affecting millions of Medicare beneficiaries. The Center for Studying Health System Change (HSC) recently released a study documenting the significant lack of Medicare beneficiary access to physician practices with fully-integrated HIT systems. The study monitored physician practice adoption trends for the following five clinical functions: obtaining treatment guidelines; exchanging clinical data with other physicians; accessing patient notes; generating preventive treatment reminders for the physician's use; and writing prescriptions.

While nearly half of the Medicare outpatient visits used at least one of these five clinical functions, according to the HSC study, only 9 percent of visits were to physician practices with electronic prescribing capabilities. The study concluded that while Medicare is targeting small practices by offering technical assistance and undertaking a

⁵ Congressional Research Service, "Health Information Technology: Promoting Electronic Connectivity in Healthcare," The Library of Congress, April 13, 2005.

chronic care pay-for-performance demonstration, “Broader policy efforts—including financial incentives —may be needed, however, to substantially improve patient access.”⁶

The Need for Immediate Congressional Involvement

The current Medicare physician reimbursement system does not reward physicians for quality. Because physicians are paid on a per-procedure or per-service basis, the Medicare reimbursement structure emphasizes volume over quality. In recognition of the need for a Medicare reimbursement system that rewards innovation and quality, Congress is examining the role that value-based purchasing programs might play in the Medicare program.

ACP strongly believes a solution to this problem lies in changing the Medicare physician payment policies to reward those physicians who fully incorporate all aspects of HIT (and value-based purchasing programs) into their practice. Under today’s Medicare payment formula, physician payments is based upon several factors: relative value units (RVUs) for each service, reflecting the relative amount of physician work effort, practice expenses, and malpractice insurance expenses involved with furnishing each service; a dollar conversion factor that translates these RVUs into monetary payment amounts; and geographic practice cost indexes (GPCIs) for physician work, practice expenses, and malpractice insurance expenses to reflect differences in physician practice costs among geographic areas.

But in order to speed the adoption of HIT into physician practices, and to take into account the *ongoing*, everyday costs associated with maintaining such systems, the College recommends Congress consider legislation that builds into the Medicare physician payment system an add-on code for office visits and other evaluation and management (E/M) services. This payment mechanism should identify that a service was facilitated by electronic health data systems, such as electronic health records, electronic prescribing and clinical decision support tools, and reimburse accordingly.

In addition, Congress should also allocate the necessary funding for small physician practices to make the *initial* HIT investment to purchase the necessary hardware and software. The majority of bills that have been introduced in the 109th Congress only utilize either grants, loans, tax credits, or a combination of the three. We believe those funding mechanisms alone are insufficient to put the necessary HIT systems into the hands of small physician practices.

Finally, the College is growing deeply concerned over the lack of coordination in the creation of uniform HIT standards. In order to facilitate the seamless and secure transition to an electronic flow of health information, Congress must push for the adoption of uniform standards for everyone to use. To date, several standards have already been developed by a mixture of public and private entities. Unfortunately, these entities are, in most cases, duplicating efforts. We believe Congress must intervene in this process and bring public and private entities together into one decision-making body

⁶ See HSC study, July 2005.

to agree on existing standards, determine what additional standards are needed, prioritize future standard development, and make sure approved standards are maintained.

ACP is very supportive of the initiative recently announced by HHS Secretary Mike Leavitt to create the American Health Information Community (AHIC), a public-private collaboration that will help develop standards and achieve interoperability of health information. This collaboration will provide a forum for interested parties to recommend specific actions that will accelerate the widespread application and adoption of electronic health records and other health information technology. We believe an entity, such as AHIC, should be recognized as the sole organization charged with developing uniform standards and certifying HIT products for industry use. **Therefore, Congress must immediately authorize and provide the sustained funding to begin the development of uniform national HIT standards.**

Once developed, HIT standards will need real-world pilot testing. This should come as no surprise to Congress given the dire situation we found ourselves in 2003 with the implementation of standards mandated under HIPAA Transaction and Code Sets Standard. As with HIPAA Standards compliance, implementation of HIT standards will require time and a significant amount of pilot testing by the full range of health care providers from all sectors with adequate HIT in place. Testing must include physicians in solo/small and large practice settings (rural and urban areas), psychologists, hospitals, community health centers, skilled nursing facilities, laboratories, and pharmacies. All participants in the pilot must utilize the full range of HIT systems and the necessary ongoing training must be provided. **Therefore, we believe Congress must provide the necessary funding to ensure adequate testing of HIT standards across all health care sectors. These pilot tests can begin immediately as standards become accepted. As additional standards are approved, they can be immediately incorporated into the pilot.**

Legislation in the 109th Congress

In the 109th Congress, a flurry of legislative proposals has already been introduced to define the federal role in speeding the adoption of HIT. ACP is supportive of many of the bills that have come forward, especially those we believe will lead to the achievement of universal acceptance and adoption of HIT. We are also appreciative of the Senate-passed FY 2006 Budget Resolution that creates a HIT “reserve fund” to permit financial incentives which will encourage the adoption of information technology for the period of fiscal years 2006 to 2010. Recognizing the quality and the cost savings benefits, the FY 2006 Budget Resolution provides the authority for the Senate Finance Committee and the Senate HELP Committee to report out language offering financial incentives that encourage the adoption of HIT, anticipating they will pay for themselves within 5 years.

The College is particularly supportive of the bipartisan bill, H.R. 747, the National Health Information Incentive Act,” sponsored by Reps. Charles Gonzalez (D-TX) and John McHugh (R-NY), because it specifically targets those small physician

practices who are in need of the most financial assistance. Like most of the legislative proposals introduced so far, H.R. 747 offsets the initial start-up costs and ongoing training and maintenance costs of acquiring interoperable HIT systems by providing grants, loans, and refundable tax credits. But more importantly, the legislation builds into the Medicare physician payment system an add-on code for office visits and other evaluation and management (E/M) services, care management fees for physicians who use HIT to manage care of patients with chronic illnesses, and payments for structured email consults resulting in a separately identifiable medical service from other E/M services. These fees would be triggered if the procedure or service was facilitated by an electronic health data system (such as electronic health records, electronic prescribing and clinical decision support tools) when used to support physicians' voluntary participation in performance measurement and improvement programs. Additionally, H.R. 747 takes the appropriate step of establishing two-year pilot testing of the standards and the determining quality improvements and cost savings of the integration of HIT.

In addition, the College is also strongly supportive of the bipartisan bill, S. 1227, the "Health Information Technology Act," introduced by Sens. Debbie Stabenow (D-MI) and Olympia Snowe (R-MA). Like the Gonzalez-McHugh bill, S. 1227 includes one-time tax credits and grants for the purchase of HIT as well as Medicare physician payment changes that recognize the ongoing costs in maintaining HIT by authorizing adjustments to Medicare payment when an identifiable medical service is provided using HIT.

The College strongly believes Congress should provide the necessary funding to offset the initial costs in obtaining HIT, but it should also recognize the unquantifiable and ongoing costs in utilizing HIT. It is this combination of *one-time* and *on-going* financial incentives put forward by H.R. 747 and S. 1227 that will substantially speed HIT adoption and improve access to physician practices with HIT, resulting in tremendous system-wide savings. **Congress should recognize the collective and individual contributions needed to achieve Medicare and Medicaid savings through the adoption of HIT. Therefore, we believe funding initiatives should allow for individual physicians to share in the system-wide savings that are attributable to their participating in HIT and other performance measurement and improvement programs.**

Conclusion

ACP is pleased that the House Committee on Ways and Means Subcommittee on Health is examining the congressional role in accelerating the adoption of health information technology. We strongly believe Congress has a very important role in promoting the adoption of uniform standards and providing the necessary initial and ongoing funding mechanisms to assist small physician practices to adopt and utilize HIT. The benefits of full-scale adoption of interoperable HIT will be significant, leading to a higher standard of quality in the U.S. health care system. Unfortunately, without adequate financial

incentives, small physician practices will be left behind the technological curve and their patients with them.

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