Written Comments of the American College of Physicians
on
Incentives to Promote Health Information Technology
for
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The American College of Physicians (ACP), representing over 115,000 internal medicine physicians and medical students, is pleased to provide written comments on the Federal role in providing incentives to promote health information technology (IT). These comments are provided for the June 17, 2004 hearing held by the United States (U.S.) House of Representatives Subcommittee on Health of the House Ways and Means Committee.

Introduction

The United States healthcare system is highly fragmented in terms of the vast array of disparate, proprietary non-communicating healthcare information systems in use. Perhaps the largest barrier to adoption of health information technology besides cost is that the current Medicare and private sector insurance plans actually incentivize physicians and other healthcare providers <u>not</u> to use medical information technology. This results from most health IT systems not being designed to communicate with other health IT systems, which has resulted in the creation of thousands of health information silos all over the country. Another problem that has contributed to the creation of the information silos is that for virtually every component of care—drugs, lab results, digital imaging, disease classification, procedures performed, and electronic health records—there are multiple terminologies in use within each component. For drugs alone, there are at least 12 separate systems for naming medications, their ingredients, dosage, and route of administration. (1) So, even if the U.S. developed a system that allowed physicians and other health care providers to easily transmit health care data and if these providers implemented the systems into their medical practice, they'd still not be using a single uniform language.

The Institute of Medicine's (IOM) 2001 report *Crossing the Quality Chasm— A New Health System for the 21st Century,* highlights the U.S. healthcare system's reticence in taking advantage of the information technology revolution "that has been transforming every other aspect of society." The IOM report warns: "In the absence of a national commitment and financial support to build a national health information infrastructure… the progress of quality improvement will be painfully slow." (2) President Bush, in his January 20, 2004 State of the Union speech, agreed that the time to bring advanced information technology to healthcare is now: "By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care." (3) The President has backed his support for expanding IT use in the healthcare sector by

earmarking $152 million in his proposed Fiscal Year 2005 budget for health IT initiatives. (4) To underscore the federal commitment to these goals, in April 2004, the President announced creation of a new position to lead the federal effort, the National Health Information Technology Coordinator and tasked the coordinator with developing a national plan within ninety days.

The American College of Physicians (ACP) agrees with the IOM's and President's call to bring the latest advances of information technology to all sectors of the healthcare marketplace, underwritten with federal support and leadership. Health information technology and creating an interoperable healthcare data system, i.e., one that allows HIT systems throughout the country to communicate with each other, will revolutionize healthcare and will give individual patients greater knowledge and ability to improve their health status. An interoperable healthcare data system will facilitate the delivery of a higher standard of quality to the U.S. healthcare system by increasing the availability of healthcare data, making care safer and less costly. As such, ACP believes creating incentives to improve health IT adoption and creating interoperability are goals well worth the effort. Achieving these goals will not be easy. It will require overcoming steep barriers of resistance to system change, and a willingness to endure what will surely be a long and taxing process of converting old systems to new. Financial incentives for health IT adoption are needed and health IT standards should be developed cooperatively and voluntarily with active provider input, with the federal government sharing in the cost of achieving the interoperability of health care data that is sorely needed. In addition, new interoperable systems be carefully tested before widespread implementation.

Even if the United States were able to overcome the enormous challenges which must be surmounted to attain a truly interoperable national healthcare information system, physicians likely would not elect to use the system and continue to use a paper-based or an unconnected legacy health IT system that is already in place in their medical practice. This is because the current Medicare and private sector insurance plans actually incentivize physicians <u>not</u> to invest in or use medical information technology. The balance of this testimony will focus on the benefits, barriers, and incentives for adopting health information technology in the physician practice and ACP recommendations for achieving this critical national goal.

Benefits of Health Information Technology Adoption in the Physician Practice

Recent reports (5-7) show that while only 5% to 9% of American physicians use electronic health records (EHRs) on a regular basis, there is a great deal of variability within geographic regions. For example, EHR adoption in Massachusetts is as high as 30.2%. (8) A much smaller number of physicians, about 0.1% nationally according to one expert in the field (9), have taken the next big step to make their practices virtually "paperless." The core of a paperless office is a system that integrates EHRs with physician practice management, patient scheduling, and clinical decision support software. Such software has the ability to facilitate many critical practice functions, including patient record keeping, scheduling and communications, issuance of bills and tracking of claims, ordering and receipt of diagnostic test information, generation and

tracking of physician referrals, measurement of physician and staff productivity and performance, internal administrative workload and budget control, and real-time clinical decision support (CDS). CDS software, such as the Physicians' Information and Education Resource (PIER), ACP's highly regarded real-time point-of-care system, delivers current medical research information and best clinical practice information to the physician at the point of care when the physician needs it. PIER aids physicians in the diagnosis and treatment of hundreds of conditions and also offers educational support to patients, with physician-selected print-outs available at the push of a button.

In its fully realized form, a paperless office can enhance the quality of care that a physician practice delivers while also offering an array of other benefits. These can include the following:

A. Instant access to patient health data from any location with a computer and Internet access;
B. Real-time clinical decision support at the point of care;
C. Updating of the EHR while the patient is being seen;
D. Digital transmission and receipt of all patient lab requests and results, physician consult requests and reports, and patient prescriptions;
E. Medication and formulary information and advice, aimed at avoiding errors and untoward drug interactions and keeping drug costs as low as possible;
F. Coding advice to physicians to assure accurate documentation of a visit's level of complexity;
G. Generation of patient bill and patient take-home medical summaries, condition-specific information, and treatment instructions for patients before leaving the office;
H. Scheduling patient appointments and sending reminders to patients about important treatment items and upcoming tests and appointments;
I. Digital transmission and tracking of claims sent to insurers; and
J. Physician performance measurement and health care outcomes research.

Technology and software already exist that would allow physicians to spend more time seeing patients and less time on paperwork; however, physicians in the United States have been slow to embrace this new technology. England has committed $17 billion to wire every hospital, clinic, and doctor's office. All of England's 50 million citizens are expected to get an electronic medical record by 2005, and, by the end of 2008, the system will handle an estimated 5 billion transactions a year, including electronic appointments, prescriptions, and access of patient records (10).

In paperless offices, all patient information is instantly available to the physician; not only in the exam room but anywhere an Internet-linked computer can be accessed. With the proper safeguards, this connectivity can be achieved over the Internet, thus allowing physicians to obtain the necessary patient information to render an appropriate clinical decision. Quality of care should be improved by eliminating the risk of having to rely only on the physician's and/or patient's memory or the patient's description of symptoms left in a telephone message.

The quality of patient care may also be enhanced by automated system reminders, which alert both physicians and patients to the need for necessary treatments and tests, such as periodic physicals, flu shots, hemoglobin A1c tests for diabetics, colonoscopies, and mammograms.

A study of small physician practices in California documented how using EHRs had had a visible impact on quality: "Quality benefits were common… almost all users reported increased quality of patient care due to better data legibility, accessibility, and organization, as well as prescription ordering, and prevention and disease management decision support" (11).

Most EHR software includes physician prompts for key clinical questions that should be asked based on past history and diagnosis, avoiding critical oversights. Prescription errors caused by illegible handwriting are avoided when physicians can simply place a check mark next to correct medication(s). Such software also provides medication conflict warnings, thereby averting potentially dangerous drug–drug interactions.

The benefits for patients and the health care system at large can be enormous. According to the Leapfrog Group for Patient Safety, computerized physician order entry for prescriptions alone can substantially reduce serious medication errors. One major Boston, Massachusetts, hospital had a 55% decrease in medication errors after its computerized physician order entry was installed, while a hospital in Salt Lake City, Utah, experienced a 70% decrease in antibiotic-related adverse drug events (12).

Barriers to Health IT Adoption in the Physician Practice

Three recent major studies that examined barriers to EHR adoption found that the largest barrier to health IT adoption cited in the studies is lack of adequate funding and resources. This finding held true in the physician and hospital sector and across the spectrum of physician practice size (13, 14, 15).

Adopting major health IT components and converting to a paperless physician office has many costs and obstacles physicians must fully weigh before making such a major change in how they do business. The time, cost, and practice disruption involved in purchasing and learning how to use a new system has to be balanced against its potential benefits and ability to recover the initial investment. Important start-up costs and obstacles that the physician must carefully consider include the following:

     A.   The cost of purchasing and/or upgrading hardware and new software.
     B.   The time and cost of system testing and customization before implementing new EHR, practice management, clinical decision support, and other software.
     C.   The cost of designing and building or redesigning and renovating the office's physical layout to accommodate a paperless operation.

D.   The cost and time of training staff to use new health IT software and related updated office protocols.

E.   The time and cost for existing practices to upload paper medical records into an electronic health record format.

F.   Short-term loss of productivity and practice revenue while the new system is being installed and debugged and staff is learning new software and office protocols.

G.   Lack of interoperability of healthcare data among health IT systems.

H.   Ongoing costs of system maintenance, upgrading, technical support, and staff training.

I.   Temporary loss of system access due to computer crashes or power failures.

J.   Use of digital data entry devices, such as an electronic stylus, electronic dictation, or a keyboard.

K.   Patient resistance to the new system's outputs, such as computer-generated bills, referrals, and prescriptions.

Software/hardware start-up costs for adopting health IT solutions and creating a paperless office depend on a wide array of factors. These factors include the number of physicians comprising the practice and deciding whether to purchase EHR/practice management/clinical decisions support software and install new servers and workstations, or to lease software and/or servers from an application service provider. Cost is also driven by the number of links to the servers, e.g., links to reference labs and to area hospitals, which allow direct electronic transmission of patient medical data. Besides initial hardware and software costs, practices need to consider ongoing costs, such as Internet access and ongoing system maintenance costs. An October 2003 report entitled "Electronic Medical Records—Lessons from Small Physician Practices," which studied 20 small practices in California, showed that "initial costs ranged from $15,000 to $50,000 per physician, with a median cost of $30,000 per physician" (11); this report focuses on EHRs, so creating a true paperless office would require an even greater capital investment.

Incentives to Health Information Technology Adoption in the Physician Practice

The vast majority of small physician groups and hospitals, as well as many large organizations, are not implementing EHRs and other health IT solutions despite the potential gains to patient safety and improved quality. The primary reason for not implementing these health IT solutions is that EHRs have an adverse financial effect on most physicians' practices and those of other healthcare providers, even if they believe the technology to be useful and efficacious. This lack of health IT adoption allows avoidable medical errors and deaths to occur while these beneficial technologies remain underused.

Despite the long term benefits realized by patients, payers, purchasers and society as a whole, physician groups and hospitals are making rational economic decisions when they choose not to invest in EHRs and other health IT solutions. Hospital and physician

investments in EHRs are costly, pose substantial economic risks and have few economic benefits to the purchasers. Despite being on the market for over a decade, demand for a robust EHR health IT solution is low because total cost of ownership (purchase price, implementation, maintenance, and impact on operations costs) is too high. EHRs are costly because of the large upfront investment needed for technology and infrastructure, but also because of the high costs of managing concomitant clinical and administrative changes. They are risky because the implementations may not succeed, and also because of the EHR-driven changes in the workflow, communication and decisionmaking processes for those who implement these systems.

The current federal approach to reimbursement of health care services did not contemplate health IT. EHRs and health IT present a new and unique category of clinical technology financing. The current Medicare reimbursement system for physicians—the Medicare Resource-Based Relative Value Scale (RBRVS)—does not recognize use of EHRs and health IT. The reason is that the use of these health care solutions are considered "atypical" and therefore not a reimbursable service under Medicare. There are no allowable billing codes for critical new health IT solutions such as e-visits/e-consults, which are structured e-mail communication between the patient and physician which allow for a cost-effective medical service to be delivered to patients beyond the face-to-face clinical setting. Thus, the Medicare payment system is a disincentive for physicians to invest in health IT solutions such as EHRs.

At the same time that physicians are considering implementing health IT solutions into their medical practices physician payment cuts are expected in 2006 due to the fundamentally flawed Medicare Sustainable Growth Rate (SGR) formula. The SGR is formula is simply unworkable; it requires Medicare actuaries to predict the unpredictable, leads to constantly-changing government cost estimates and creates volatile payment swings that undermine medical practices' ability to make rational business decisions such as health IT investment and remain financially viable. The Congressionally-created Medicare Payment Advisory Committee (MedPAC), recommends replacing the SGR. Medicare reduces payments to physicians and other practitioners whenever program expenditures for their services exceed a set target, the SGR. At the same time, however, the government induces greater use of physician services through new coverage decisions, quality improvement initiatives and a host of other regulatory decisions that are good for patients but are not recognized in the SGR. Of particular note, the SGR does not properly account for investment in health IT. As a result, from 1991-2004, payment rates for physicians and health professionals fell 15% behind practice cost inflation as measured by Medicare's own conservative estimates. As such, ACP supports MedPAC's recommendation to replace the SGR with an annual update system which, like those of other Medicare providers, reflects actual increases in physicians' costs.

The solution to properly incentivize healthcare providers to invest in health IT is multilayered. Physicians and other health care providers need access to capital to make the investment in health IT. One way to do this is to create a government-backed loan program. The interest in EHRs among hospitals and physicians and the frequently cited financial barriers suggest that strong latent demand for these systems would be stimulated

by capital availability. Cost offsets may be particularly beneficial to physician practices, independent hospitals, and other small organizations such as public sector clinics and agencies, for which capital is particularly scarce and where cash flow inhibits investment in health IT and specifically EHRs. Loan funds should be made available for more than just the purchase of an EHR system, it must cover the cost of EHR purchase, implementation, training and concomitant workflow changes that are necessary to lower implementation risk and deliver results from EHR implementation. The program also should be structured so that health IT purchases support systems that promote national goals such as interoperability of healthcare data, not proprietary, unconnected health IT systems.

Once the investment capital is made available, the purchasers of these health IT systems must have a means to pay these purchases off. Therefore, Medicare and private sector payment policy must be changed to encourage, rather than discourage the use of health IT. The Medicare SGR formula must be replaced with a more coherent payment update formula and the Medicare RBRVS must explicitly pay for the use of health IT.

Legislative Recommendations

It's clear from the benefits discussed in this testimony that investment in health IT solutions are a sound investment for the future health and well-being of Americans. In order to stimulate investment in health IT, ACP recommends that Congress consider enacting legislation that will incentivize physicians to acquire HIT, including consideration of the following options:

1. **Create a revolving health IT loan program—modeled on the current student loan program—for physicians and other health care providers interested in investing in health IT with clinical decision support tools designed to be interoperable and to enhance medical practice to improve the quality of care delivered.**

2. **Create a grant program to provide direct dollar subsidies to physicians who agree to acquire health information technology linked to clinical decision support tools and who agree to voluntarily participate in performance measurement/quality improvement programs and/or in studies to assess the impact of such HIT systems on improving health care quality while achieving system-wide savings.**

3. **Authorize the creation of tax credits, specifically targeted to physicians in small and solo practices, for the purchase of HIT with clinical decision support, conditioned on an agreement by the tax credit recipients to participate in performance measurement/quality improvement programs and/or in studies to assess the costs and benefits of HIT linked to quality improvement.**

4. **Replace the flawed Medicare SGR formula for physician payment with a new formula that provides for recognition of the acquisition and ongoing costs associated with HIT systems.**

5. **Build into the Medicare RBRVS system an add-on code for evaluation and management (E/M) services to identify that the E/M service was assisted by an EHR with clinical decision support tools designed to be interoperable. The add-on code would increase payment for the identified service by an amount that not only recognizes the investment of dollars and practice resources required to acquire and maintain such technologies but also the ongoing system-wide value to Medicare associated with use of such technologies**

6. **Recognize and separately reimburse telephone and e-consults (structured email communication between patient and physician or other health care provider) that result in a distinctly identifiable medical service.**

7. **Authorize Medicare payment of a "case management fee", which would provide additional reimbursement per patient per month for physicians who agree to acquire and utilize HIT with clinical decision support to manage and improve care of patients with chronic illness.**

8. **Exempt such additional reimbursement incentives from Medicare budget neutrality requirements. Because Medicare is likely to experience system-wide savings associated with an investment in HIT, creating on financial incentives to support the acquisition of such cost-saving technologies should not be subject to budget neutrality cuts.**

ACP has developed a draft legislative proposal to authorize the incentives described above and to require development and testing of HIT standards. We would be pleased to share the draft proposal with the Ways and Means Committee.

Conclusion

Organizations that invest in health IT generate benefits for their patients and for health care purchasers, but often realize lower revenue (e.g., prevented hospitalizations and reduction of redundant medical services) and increased costs from supporting the health IT. Even if EHRs and other health IT products were free to purchase and use, and could be implemented in a risk-free manner, the financial consequences of the changes they induce in health care organizations slows adoption substantially because the current payment system incents providers not to adopt health IT solutions. The financial penalties of health IT and EHR use are a direct consequence of the obsolete reimbursement methods used by Medicare and private insurers. These methods of reimbursement are misaligned with society's needs and health care's mission, and require fundamental reform.

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