CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
Wednesday, March 11, 2015

SB 812, An Act Concerning Electronic Health Records And Health Information Exchange

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 812, An Act Concerning Electronic Health Records And Health Information Exchange**.

Before commenting on the bill, it's important to point out that Connecticut hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay.

This is a time of unprecedented change in healthcare, and Connecticut hospitals are leading the charge to transform the way care is provided. They are focused on providing safe, accessible, equitable, affordable, patient-centered care for all, and they are finding innovative solutions to integrate and coordinate care to better serve their patients and communities.

SB 812 attempts to tackle a wide variety of healthcare-related information technology (HIT) issues. Some of the bill's goals are straightforward, and we hope these goals can be achieved successfully and cooperatively. Unfortunately, there are portions of the bill that (1) conflict with federal laws, which would create substantial risk to the integrity of medical records, and (2) are not possible to achieve at a state level or by the adoption of a state law.

Sections (1) and (2): Creating a Workable Health Information Exchange

Sections (1) and (2) of the bill provide that:

(1) The general statutes be amended to promote the establishment of interoperable electronic health records systems in all health care provider settings and a state-wide health information exchange to enable the secure exchange of health information between health care providers regardless of the health care provider's affiliation, location or health record technology.

(2) The general statutes be amended to designate "eHealth Connecticut" as the entity for advancing the use and adoption of electronic health records in all health care provider settings and for coordinating and integrating public and private health information technology and information exchange efforts in the state.

We applaud the goal to cultivate a viable, statewide health information exchange (HIE) in Connecticut. Connecticut has already spent close to $8 million dollars with very little or no results. The earlier, multiple efforts that ultimately failed to launch an HIE were the combined result of too little content expertise and an unwillingness to engage providers, patients, and patient advocates fully in the design. CHA and hospital health IT professionals were among the scores of providers and advocates who volunteered for countless committees and meetings in the hope of offering perspectives. But Connecticut's efforts were not aligned appropriately with the needs of the provider community and critical patient privacy and security laws.

To the extent that Sections 1 and 2 of SB 812 are meant to reignite the effort to achieve an affordable, meaningful, and accessible HIE, we have substantial common ground, and we stand ready to join in those efforts. But we urge strongly a different approach than in prior efforts. Specifically, experts in the field – health IT experts, providers who would be using the system, and patient advocates – must be involved and have their voices heard at every step of the HIE's development.

Additionally, we note that the federal government is taking the lead in setting the technological framework for an interoperable and widely accessible healthcare environment as outlined in the recent draft report, *Connecting Health and Care for the Nation, A Shared Nationwide Interoperability Roadmap*, issued by the Office of the National Coordinator for Health Information Technology (ONC) on January 30, 2015. The ONC is part of the U.S. Department of Health and Human Services, and the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology to facilitate the electronic exchange of health information.

ONC's report concludes that the move toward interoperability in Health IT will take another ten years, and ***must be directed at a national level***. This is the conclusion reached by all experts in Health IT. Connecticut law cannot mandate a faster reality. These IT changes must be undertaken in a measured manner consistent with the federal roadmap.

We respect and support the establishment of a state HIE but urge that we follow the lead of the federal government when assisting Connecticut with the challenge of improving the healthcare system, including efforts to reach reliable interoperability across the care continuum through a steady and planned process.

We believe that the high-level goals of SB 812 can be met through a cooperative, planned approach as set forth in Sections 1 and 2, and we look forward to working with this Committee and other stakeholders to reach these important goals.

Sections (4), (5), and (6): Technology Sharing

Sections 4, 5, and 6 provide:

(4) The general statutes be amended to require each hospital to adopt an interoperable health records system and enable bidirectional connectivity for the secure exchange of patient health records and information between the hospital and other licensed health care providers using certified electronic health record technology.

(5) The general statutes be amended to prohibit any hospital, in implementing its interoperable health record system, from (A) requiring a health care provider to pay for any hardware, software or other internal cost associated with the hospital's implementation of its health records system, (B) charging any fee for connecting to, or exchanging information through, the hospital's health records system, (C) refusing to implement any available hardware, software or other functionality that would support such exchange, and (D) requiring a health care provider to adopt, add to or modify any information technology.

(6) The general statutes be amended to require each hospital to support, to the extent permitted by federal law, the adoption and implementation of electronic health records systems by independent health care providers who refer patients to the hospital by funding eight-five per cent of the information technology, software and training costs associated with the health care provider's adoption of electronic health records systems and paying for any electronic interface necessary to allow the health care providers' electronic health records systems to communicate with the hospital's system.

These sections are contrary to the federal laws relating to EHR operations and functionality, the rules for donation of certified EHR, the IRS rules regarding private inurement and private benefit, and privacy and security requirements. Moreover, they are not coordinated with the technological realities of the national framework for achieving a sustainable health information ecosystem. Our specific concerns are set forth below.

Currently, all hospitals in Connecticut operate health record systems that are capable technically of supporting appropriate connectivity with other systems, and that allow for interoperability with a variety of other health IT systems and components. These systems are highly complex, incredibly expensive, and built over a period of years. The systems are not static. They require continuous improvement, technical upgrades, monitoring, and ongoing maintenance. Security requirements include not just protecting against intrusion or theft, but also ensuring the integrity of the record.

Ensuring the integrity of a medical record necessarily includes – by law – having technical features and administrative policies to: limit the type of records that can be accessed; set the thresholds for who should have access and under what circumstances; set policy on who can enter information into the record; and have technical features to monitor record access and activity. A hospital or practice has a duty to ensure record integrity.

Section 4 of the bill appears to seek that hospitals and providers have a bidirectional "open records" system to exchange medical information, without regard to the various requirements, risk protocols, risk assessments, or technology concerns that exist in current state and federal privacy and security laws, as well as industry standard practices. Under the proposed bill's language, the only qualification for being able to access a hospital's record (or for a hospital to access the practitioner's record) appears to be having the status of a licensed healthcare provider. ***Federal law does not permit that level of unchecked access***. Access to medical record systems is, at all times, subject to all federal privacy and security rules, including the vetting, validation, selection, and approval processes as set forth by each covered entity's privacy and security safeguards. Federal law preempts any dilution of patient privacy rights or security standards.

Sections 5 and 6 of the bill attempt to mandate that hospitals *donate* EHR technology to physician practices. Federal tax law does not support such a mandate as it would be transferring not-for-profit assets for the private benefit of for-profit entities. Federal fraud and abuse laws also do not support the required "donation" to physician practices.

Under defined circumstances, federal rules permit the *voluntary donation* of very specific, and highly limited, EHR system support, but such donations are subject to a multitude of requirements. The federal requirements include several essential elements that cannot be met under Sections 5 and 6 of the bill:

- The physician or practice cannot possess equivalent items or services.
    - If the physician or practice has an EHR with similar functionality already, the donation cannot be made without violating federal law.

- The donation may include software only, as well as training on the software and software support. The donation may <u>not</u> include hardware, manpower, associated technology infrastructure, or overhead.
    - Section 5, almost in its entirety, would conflict with federal law.

- A physician receiving the donated items and services must pay the hospital – in advance – 15 percent of the cost for the items and services. The hospital may not loan, subsidize, or finance the 15 percent. Additionally, there may be tax consequences to the physician or practice for the donated 85 percent.
    - Hospitals lack the funds to outlay 85 percent of the cost of software and training for every practitioner. The federal rules contemplate voluntary donations.
    - Even if it were legally permissible (which we contend it is not), the cost would be prohibitive for hospitals.

- The donation arrangement must: be in a written agreement that is signed by the parties; specify the items and services, cost, and the practice's contribution amount; and cover all of the items and services provided between the parties.
    - The federal donation law and regulations contemplate only voluntary subsidization of physician EHR adoption; as such, entering the required contract is also voluntary.

Sections (7), (8), (9), and (10): Funding

The cost of implementing and maintaining HIE is extraordinarily expensive. Under the existing HITECH meaningful use incentive programs, providers and hospitals in Connecticut alone have qualified for more than $130,000,000 in IT incentives funding already. That $130,000,000 covered only *a fraction* of the actual costs incurred, with far more work and expense left to be managed. Upgrading and implementing the desired health IT infrastructure is far more complicated than the federal government anticipated. Low-interest loans and tax credits to support providers' efforts would be helpful, and we support their establishment.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.