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November 15, 2016

The Honorable Lamar Alexander
Chairman, Committee on Health, Education, Labor, and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Patty Murray
Ranking Member, Committee on Health, Education, Labor, and Pensions
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray:

Thank you for your continued engagement with the health IT community as the Committee works to find common ground on the 21st Century Cures/Innovations legislation. It has come to our attention that Committee staff may be looking into ways to improve the ratings system for health IT proposed in the Senate version of the bill. With that in mind, we would like to weigh in regarding ways in which the proposals might be improved.

The Electronic Health Record Association (EHRA) understands and supports the Committee's goal of ensuring that providers have the information they need to make good health IT purchasing decisions. And, we believe there are steps the Office of the National Coordinator for Health IT (ONC) could take to make this information more transparent and more widely available.

However, we do have significant concerns that charging ONC with creating an entirely new ratings system could be duplicative, inefficient, and burdensome for both vendors and providers who already provide feedback to numerous private sector ratings organizations. We believe that ONC could do more to harness the power of these ratings services that already exist and to ensure that this information is in the hands of providers in a transparent way before they make purchasing decisions. With that in mind, we propose a compromise wherein ONC would collect and publish existing ratings instead of independently collecting data and feedback from users. They could build on the work already being done and take steps to make sure that the information is widely available.

Specifically, we recommend that the legislation direct ONC to (1) create a mechanism to make the existing ratings more broadly available to the market as a whole, and (2) provide information about each of the available ratings systems to help purchasers differentiate between them. Existing private-sector solutions – including American EHR, Black Book, Captera, Consumer Affairs, EHR Compare, EHR in Practice, EHR Software Insider, Forrester Research, Gartner, KLAS, and Software Advice – could be among those leveraged through this method. This approach could, in our view, include data sharing between ONC and the ratings organizations, subsidizing licensing fees for small provider practices, and/or requiring designated ratings organizations to make a more robust ratings report generally available via ONC channels. In addition, we recommend the legislation direct ONC to work with designated ratings organizations to ensure that provider input is a critical component of their ratings methodologies.

Some funding for ONC to manage this program will be required, but we believe this approach would be far more efficient and less costly than charging ONC with standing up a new and duplicative data collection and analysis apparatus.

Health IT vendors take the ratings of these private sector organizations very seriously and devote considerable resources to providing them with the information and demonstrations they need to evaluate our products. Member companies of the EHRA work steadily to address areas of concern and to improve our various individual ratings. This competitive environment should be harnessed by ONC and made more transparent to providers. By avoiding the creation of yet another duplicative structure that would at best mirror what is already being done, we believe ONC can give providers the information they need in a way that is more efficient and less duplicative.

We also want to reiterate our commitment to developing solutions and working with our customers to achieve widespread interoperability among healthcare provider organizations. The ONC's annual report to Congress says that nearly half of all office-based U.S. doctors shared patient health information with other providers last year, but goes on to assert that information blocking "is occurring and may become even more prevalent as electronic health information sharing increases."

In fact, to the contrary, our member companies have been helping their customers share patient information for many years. The EHR Association created its EHR Developer Code of Conduct to include specific language regarding this commitment for adopters of the Code:

Recognizing that data should follow the patient:

- *We will enable, to the greatest extent possible, our clients to exchange clinical information with other parties involved in the care of a patient, including those using other EHR systems, through standards-based technology.*
- *We will use available, recognized, and nationally-uniform standards to the greatest extent possible in developing interfaces.*
- *As clients implement interfaces and work to achieve interoperability, we will share best practices with them about safe deployment, implementation, and use of the supporting tools and technologies.*
- *We will work with our clients to facilitate export of patient data if a client chooses to move from one EHR to another. We will enable, at a minimum, the export of one or more standards-based clinical summary formats such as CCD/CCDA (or the then-current equivalent) for all patients.*
- *We will be transparent, to the greatest reasonable extent, with clients regarding pricing and costs to our clients related to interoperability products and services that we offer. We will*

also provide information on other potential products and services provided by third parties necessary for interoperability with our EHR.

- Given our strong support for interoperability, adherents to the Code do not engage in data blocking.

As discussed during our briefings on interoperability for Hill staff in 2015 as well as earlier this year, physicians and other healthcare executives point to their accomplishments in this area, citing challenges related to incentives, not to lack of their vendors' support.

We'd be happy to discuss the specifics of these topics with you and provide additional information that might be helpful as the Committee and staff contemplate final passage of this important legislation.

Sincerely,



Sasha TerMaat
Chair, EHR Association
Epic



Richard Loomis, MD
Vice Chair, EHR Association
Practice Fusion

HIMSS EHR Association Executive Committee



Hans J. Buitendijk
Cerner Corporation



Leigh Burchell
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Rick Reeves, RPh
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About the EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of over 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families.

The EHR Association is a partner of HIMSS. For more information, visit www.ehrassociation.org.

CC:

Melanie Egorin, Professional Staff, House Committee on Ways and Means

Sarah Levin, Professional Staff Subcommittee on Health, House Committee on Ways and Means

James Paluskiewicz, Professional Staff, House Committee on Energy and Commerce

Mary Sumpter Lapinski, Health Policy Director, Senate Committee on Health, Education, Labor, and Pensions

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