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August 28, 2019

Committee on Finance
United States Senate
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden,

On behalf of the Electronic Health Record (EHR) Association, we are pleased to provide you with our perspective and expertise as the Senate Committee on Finance continues its efforts to promote price transparency and reduce costs for prescription drugs, as proposed in the draft Prescription Drug Pricing Reduction Act (PDPRA) of 2019.

The EHR Association's 32 member companies serve the vast majority of hospitals, post-acute, specialty-specific, and ambulatory healthcare providers using EHRs across the United States. Our core objectives focus on collaborative efforts to accelerate health information and technology adoption, advance information exchange between interoperable systems, and improve the quality and efficiency of care through the use of these important technologies.

EHR Association members appreciate the Committee's desire to drive down prescription drug costs through increased pricing transparency, in part by expanded provider use of real-time benefit tools (RTBT). We are concerned that as drafted this legislation may inadvertently introduce burden while slowing down the adoption of important tools by users of health IT, outcomes that would run contradictory to the Committee's goals.

The provision proposed in Section 125 of the draft PDPRA, to add a requirement to include RTBT to the definition of a "qualified EHR" under the ONC Health IT Certification Program, raises concerns for EHR Association members. *Including any certification requirements as part of statutory language will negatively impact prescribers, providers, and health IT developers, leading to increased burden, increased cost, and ultimately creating a barrier to the adoption and use of these valuable tools.*

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As EHR developers, we work closely with the users of our products to develop technology that serves their needs in a manner that fits each user's workflow. To support this flexibility, and because the downstream effects of changing requirements for certification is a long, difficult, and expensive process, we oppose including specific tools, features, functions, or dashboards *by statute* into the definition of a qualified EHR. If changes are being considered, the EHR Association recommends that updates to the definition of a qualified EHR be handled through the rulemaking process, which allows for a public comment period during which affected stakeholders can offer feedback on timelines and details of implementation.

Specific to RTBT, we have the following concerns, which could be effectively addressed through rulemaking rather than by statute:

- The EHR Association advocates for clear standards, because broadly-accepted standards are critical to successful implementation for technology developers. The National Council for Prescription Drug Programs' (NCPDP) proposed standard for RTBT is currently going through the standards-making process and has been, as such, classified as a beta standard--not yet ready to be named for widespread adoption but instead to be piloted. We support the Committee recognizing the importance of the NCPDP for standard-setting in the conceptual language, but we ask the Committee to refrain from naming a specific standard *in statute* as a requirement, noting that as technology advances, standards will change more rapidly than laws. Existing regulation covering the definition of a qualified EHR already has processes in place to deal with the pace of standards adoption.
- No existing RTBT network (CenterX, CoverMyMeds, RxRevu, Surescripts, and others) maintains an electronic connection to all Part D plans or pharmacy benefit managers. While some may use historical data to estimate patient pricing, all RTBT networks have limitations to their payer breadth and accuracy. Healthcare organizations deal with such limitations today by choosing to contract with the RTBT checker or checkers that cover the majority of the patients they serve. Adding RTBT functionality to the definition of a qualified EHR could inadvertently force that EHR to choose and bundle a specific RTBT tool, which would limit the applicability to that EHR's users. A regulatory approach, by which EHR support *for the associated standards* is promoted through rulemaking, allows for a market-driven competitive landscape that incents RTBT providers to expand their coverage and compete to provide the best, most affordable product for the industry. Bundling RTBT checkers into certified software nullifies these market pressures.
- RTBT is already in use through insurance portals, clinical decision support models, and other health IT products which are not currently subject to certification. In these examples, RTBT is built into existing workflows. Under the current draft of PDPRA, Section 125, those users would need to transition their current approach to a different workflow in order to be in compliance, introducing disruption without a clear benefit.

EHR Association members stress our support of the Committee's intent. RTBT is a valuable tool for prescribers and patients to help determine an individual's prescription drug coverage, and such tools are already being adopted by many of our members (see [RTBC scorecard-EHR availability](#)). The industry is making progress on this important issue, and when standards have matured, adjusting the definition of a qualified EHR through rulemaking would be appropriate.

Thank you for your leadership on these important issues. We look forward to continuing to work with you and your staff to achieve our shared goals. Please contact Sarah Willis-Garcia, EHRA Program Manager, at swillis@ehra.org or 312-915-9518 with questions or for more information.

Sincerely,

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