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August 17, 2018

The Honorable Mike Kelly
Co-Chair, Health Care Innovation Caucus
U.S. House of Representatives
1707 Longworth House Office Building
Washington, DC 20515

The Honorable Ron Kind
Co-Chair, Health Care Innovation Caucus
U.S. House of Representatives
1502 Longworth House Office Building
Washington, DC 20515

The Honorable Markwayne Mullin
Co-Chair, Health Care Innovation Caucus
U.S. House of Representatives
1113 Longworth House Office Building
Washington, DC 20515

The Honorable Ami Bera
Co-Chair, Health Care Innovation Caucus
U.S. House of Representatives
1431 Longworth House Office Building
Washington, DC 20515

Dear Representatives Kelly, Kind, Mullin and Bera,

On behalf of the Electronic Health Record (EHR) Association, we are pleased to provide you with our perspective and recommendations as the Health Care Innovation Caucus begins to identify the areas where its efforts will be most impactful.

The EHR Association's 34 member companies serve the vast majority of hospitals and ambulatory care providers using EHRs across the United States. Our core objectives focus on collaborative efforts to accelerate health information and technology (IT) adoption, advance interoperability, and improve the quality and efficiency of care through the use of these important technologies. Our feedback, as follows, is focused on several questions most suited to our areas of expertise.

Value Based Provider Payment Reform

What Barriers in each of the following areas limit the full potential of innovation in Medicare and Medicaid?

- **Payment and reimbursement**
- **Policy and regulation**
- **Data and reporting**

EHRs play a critical role in supporting the development of value-based payment models and can help track performance, utilization, and adherence to clinical standards. However, harmonized reporting requirements across CMS programs and across state lines would enable increased interoperability. Additionally, harmonized health IT requirements across value-based models (e.g. CPC+), with a focus on the essential health IT standards/requirements, would increase interoperability and aligns with CMS' Meaningful Measures effort to focus on core measures that are directly tied to patient care and improved clinical outcomes.

EHRA supports efforts to modernize the Physician Self-Referral Law, also known as the "Stark Law," to increase provider participation in value-based payment models. Specifically, we believe any risk-bearing entity under an alternative payment model (APM) that qualifies as an Advanced APM under the Medicare Quality Payment Program (QPP) should be eligible to be a donor of EHR technology and services under the exceptions to the physician self-referral law and the anti-kickback statute.

Similarly, any provider participant in an APM that qualifies as an Advanced APM under the QPP should be eligible to receive donations under the exceptions of either the self-referral law or the anti-kickback statute. EHRA believes CMS has the authority to consider including recipients such as post-acute care providers, skilled nursing facilities, long-term care hospitals, intermediate rehabilitation facilities, and home health agencies in the definition of "recipient" under the anti-kickback statute exception.

EHRA recommends an exception to the Stark Law to allow for the subsidizing of cybersecurity needs such as cybersecurity software, cybersecurity hardware, cybersecurity training, tools for threat information sharing, and hardware. Additionally, we recognize that having the right tools is not enough and that updates to the Stark Law should make exceptions for operational support such as IT assistance and other skilled services to aid smaller organizations with deployment and maintenance of these cybersecurity solutions.

How can we develop better outcomes measures that accurately reflect quality, safety, and value without burdening innovation?

EHRA encourages a focus on useful quality measures that reliably track performance. We encourage policymakers to ensure adequate transition time (18 months) between program and measure changes, so that EHR developers and end-users have appropriate time to effectively and accurately implement changes.

<u>Technology & Health IT</u>

What impact does Health IT and data interoperability have on successfully running value based payment models and contracting? What are some ways to improve interoperability and the sharing of data?

At the core of value-based payment models is the free flow of secure data exchange to enable a common view of the patient record and utilization of resources. Widespread use of common, well-defined interoperability and terminology standards will reduce time to implement, provide the stability

and infrastructure needed to enable these models to succeed as they cross organizational boundaries, and increase value overall. This should include use of a consistent, unique patient identification method to reduce if not eliminate false positives/negatives resulting from current patient matching methods necessitated by the absence of a common, unique identification method at a national level. We therefore support considerations to remove the current prohibition to use federal funds to promulgate or adopt a standard for a unique patient health identifier.

Full interoperability requires that all healthcare providers be equipped to use standards-based, interoperable health IT, including EHRs, to accurately and efficiently share data. For example, behavioral health occupies a critical part of the healthcare delivery system, but has never been incented or given the financial means to adopt health IT at the same pace as the remainder of the healthcare market. EHRA has encouraged support for passage of the Improving Access to Behavioral Health Information Technology Act (HR 3331/S 1732), introduced on a bipartisan basis in the House by Representatives Mullin, Jenkins and Matsui, and in the Senate by Senators Portman and Whitehouse. This legislation and alignment of 42 CFR Part 2 with the protections under the Health Insurance Portability and Accountability Act (HIPAA) would take important steps toward improving healthcare for persons with serious mental health and substance use disorders through healthcare information technology.

What new technology exists to lower costs, improve efficiency, or improve the quality of care that isn't already widely adopted?

EHRA believes there are a number of promising technologies that if fully evaluated and meaningfully implemented could offer a multitude of benefits to all healthcare stakeholders. A few examples, we'd like to highlight:

- **Telehealth**

  Telehealth technology is becoming increasingly used by healthcare systems. Not only leveraged by small or rural care settings, telemedicine is seen as an opportunity for all healthcare deliverers to offer services more conveniently and more cost effectively.

- **Clinical decision support (CDS) software**

  CDS software is a critical and growing tool within healthcare. It can play a central role in leveraging volumes of data to aid healthcare professionals in clinical decision-making. As the EHR is the primary mechanism by which CDS is presented to healthcare organizations and providers, EHRA members are committed to ensuring patient safety and enabling the advancement of innovative decision support tools that improve patient care. The 21st Century Cures Act provided legislation aimed at clarifying the role of the Food and Drug Administration (FDA) in regulating health IT, specifically CDS. EHRA actively engages and provides public comment to the FDA as they continue efforts to operationalize this legislation.

- **Artificial intelligence (AI)**

  EHRA members recognize the potential of artificial intelligence (AI) as an advanced technology that holds promise in its application to healthcare. Not widely used, further evaluation is necessary, especially in the application and oversight of machine learning/artificial intelligence, which will play a key role in the future of CDS development.

- **Widespread provider adoption of national health information exchanges/networks** (e.g., Commonwell, eHealth Exchange, Carequality, Direct)

- **Patient focused applications**

Increased patient engagement has the opportunity to improve care coordination and outcomes.

Thank you for your leadership on these important issues. We look forward to continuing to work with you and your staff. Please contact Sarah Willis-Garcia, EHRA Program Manager, at swillis@ehra.org or 312.915.9518 with questions or for more information.

Sincerely,

Cherie Holmes-Henry
Chair, EHR Association
NextGen Healthcare

Sasha TerMaat
Vice Chair, EHR Association
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HIMSS EHR Association Executive Committee

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About the EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of more than 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.ehra.org.