HIMSS Electronic Health Record Association

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The Honorable John Thune
United States Senator
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The Honorable Richard Burr
United States Senator
217 Russell Senate Office Building
Washington, DC 20510

The Honorable Lamar Alexander
United States Senator
455 Dirksen Senate Office Building
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The Honorable Tom Coburn
United States Senator
172 Russell Senate Office Building
Washington, DC 20510

The Honorable Pat Roberts
United States Senator
109 Hart Senate Office Building
Washington, DC 20510

The Honorable Mike Enzi
United States Senator
379A Russell Senate Office Building
Washington, DC 20510

Dear Senators:

The Electronic Health Records Association (EHR) is pleased to respond to your request for comments in your recently authored white paper, “Reboot: Re-examining the Strategies Needed to Successfully Adopt Health IT – April 2013”.

Established in 2004, the EHR Association is comprised of more than 40 companies that supply the vast majority of operational EHRs to physicians’ practices and hospitals across the United States. The 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.

We appreciate your attention to the topic of health information technology (IT) and its role in improving the delivery of healthcare in US. As EHR developers with employees and users on the front lines of healthcare delivery through the adoption and use of health IT, we understand very well the five concerns you address. We agree that in order for providers to best leverage health IT towards the aims of meaningful use and interoperability, Congress and the administration as well as providers and health IT developers will have to work together closely.

With our collective experiences and roles in delivering and implementing products for use as part of the EHR incentive program, we hope to offer additional perspectives on each of your five areas of concern.

1. Lack of Clear Path Toward Interoperability

Although nationwide exchange of health information has not yet been fully achieved, Stages 1 and 2 of the EHR Incentive Program and ongoing industry efforts have made significant advances toward broad interoperability.

In fact, interoperability among health IT systems exists widely today within healthcare organizations. And with growing numbers of health information exchanges (HIEs) and the availability of newer models of exchange (e.g., the Direct protocol and Integrating the Healthcare Enterprise (IHE) document management profiles), interoperability is rapidly increasing among provider organizations. The EHR Association has supported ONC's Direct project as a simple and powerful methodology, built on Internet standards, to connect providers. It is secure, scalable, and standards-based, and offers a useful entry point to begin exchange across organizations without many of the upfront infrastructure investments needed to support more advanced interoperability. The eHealth Initiative's *2012 Report on Health Information Exchange: Supporting Healthcare Reform*[1] indicates an increase of 17% in the number of HIE organizations since 2011, with over half of 109 respondents reporting support for new payment and delivery models such as accountable care organizations (ACOs) and patient-centered medical homes.

There is, of course, a substantial increase in complexity to attain interoperability when moving from connections within a single healthcare organization to attaining the same level of interoperability across provider organizations. Within a healthcare organization, a limited number of systems need to be connected, where alignment on a common vocabulary, data content, technology, etc., involves a limited number of stakeholders. Attaining effective interoperability across providers involves many more stakeholders to resolve variations across thousands of different systems and implementations**.** Achieving this level of interoperability cannot happen overnight, but it is progressing rapidly and will be accelerated by requirements and capabilities in Stage 2 of meaningful use, as well as a result of a growing emphasis on delivery and payment system reforms, which are beginning to drive a real need for interoperability among stakeholders.

Although EHRs play an important role in facilitating interoperability and exchange, achieving these goals requires investments in infrastructure and governance policies, both beyond the scope of EHRs and individual providers. The growth of ACOs and new payment models, along with new provisions of the meaningful use program included in Stage 2, are increasing demand for interoperable data exchange across providers. The business case for the needed investment is becoming clearer at the very time that EHR capabilities are being enhanced to support such exchange.

[1] 2012 Annual HIE Survey Results - Report on Health Information Exchange: Supporting Healthcare Reform

From its inception, the EHR Association has advocated for interoperability through support of standards development initiatives. Our member companies are leaders in developing and adopting such standards. Indeed, many interface with competing and complimentary systems in hospitals and other provider settings, and have done so for decades.

The Association published its first *Interoperability Roadmap* in 2006, and has continued to offer this document as a guide for health IT developers in implementing a common foundation of interoperability standards so disparate systems can accurately and securely exchange patient data. Version 3[2], like earlier versions, is available to the industry, and aligns with federal initiatives (e.g., Direct) and the Nationwide Health Information Network (NwHIN), which has transitioned to a public/private effort, Healtheway, Inc.

The Association has consistently urged the federal government to enact policies that enable and support standards-based interoperability and exchange. We reinforced our call for robust interoperability standards and requirements in comments on Stages 1 and 2 of meaningful use, and in our response to the recent proposal of the Health IT Policy Committee on Stage 3.

We believe that Stage 1 established an important foundation for interoperability, and Stage 2 substantially accelerates this progress through increased rigor in standards, certification criteria, and meaningful use measures for clinical summaries, vocabularies, and data transport across providers and EHRs at transitions of care. For Stage 3, we recommend a more dedicated focus on care coordination and outcomes improvement requiring interoperable EHRs instead of some of the focus on broader feature/function capabilities included in the Stage 2 program.

The EHR Association supports the shift from a healthcare system that relies on inefficient and incomplete exchange of patient data based on paper flow, to a much more interoperable system in which providers are given a business case to promote the exchange of health information throughout the healthcare ecosystem. Our member companies continue to invest interoperability resources in their products and services, as well as in supporting standards development and testing initiatives. We share the belief that transforming the way healthcare is delivered requires effective interoperability among providers, across communities and, eventually, across the nation.

2. Increased Costs

Although the cost of care delivery is a critical consideration in healthcare reform, we do not believe that data shows that EHRs or health IT have led to inappropriate or inaccurate coding or ordering of unnecessary care. In addition, there is evidence that suggests that the use of EHRs can, in fact, decrease costs through the use of clinical decision support and other capabilities.

EHRs may allow documentation of services that were not easily documented in a paper world, but this capability allows for more accurate documentation and payment for the care that is delivered. Misuse of documentation can as easily occur in a paper environment as an electronic one. It is important not to undermine the ability of EHRs to make documentation more structured and efficient, nor their potential to lay the framework for a reformed delivery system. Such reforms, with payment shifted from fee-for-

[2] EHR Association Interoperability Roadmap Version 3

service to value-based-payment, will be critical to reducing any increased costs to the system stemming from more accurate documentation and billing.

Ultimately, we believe that it is appropriate and necessary for our software, services, and business practices to support our customers' needs to efficiently create complete and accurate documentation.

3. Lack of Oversight

Although the Centers for Medicare and Medicaid Services (CMS) have cited payment data as a main indicator of EHR incentive program participation rates, the following data also clearly indicate an increase in the adoption of health IT— a critical gateway to any advances made through the use of health IT— and advanced usage. We emphasize that the benefits of EHRs and increased provider use of EHRs include but are not limited to interoperability, a somewhat limited view of the value of EHRs that is suggested in the white paper in its discussion of CMS and Office of the National Coordinator for health IT (ONC) metrics for success. As has been the case in other industries, having a larger number of users of EHRs and other health IT can only lead to greater advances; and in the case of healthcare, increased adoption actually increases the benefits from and likelihood of interoperability.

- As of February 2013, over 388,000 eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals were registered in the Medicare and Medicaid EHR incentive programs. Of the nearly 4300 hospitals (85% of all hospitals) registered, over 3700 (75%) have earned an incentive payment or achieved meaningful use (73%).
- Moreover, according to a recent ONC analysis, hospitals are showing high and growing levels of adoption of specific meaningful use functions. For example, hospital adoption of computerized physician order entry (CPOE) for medication orders increased from 27% in 2008 to 72% in 2012.
- CMS reports that nearly 73% of EPs are registered for the meaningful use program, nearly 36% of Medicare EPs have achieved Stage 1 meaningful use, and about 44% of Medicare and Medicaid EPs have made a financial commitment to an EHR.
- Physician EHR adoption has increased substantially according to the National Center for Health Statistics, which reported that 72% of physicians had adopted EHRs as of 2012, up from 57% in 2011.
- Likewise, a recent Commonwealth Foundation report[3] indicates that 69% of primary care physicians used EHRs in 2012, up by 50% from 2009.

CMS has been conducting extensive post-payment audits and has recently initiated pre-payment audits, and the EHR Association is not aware of any evidence of widespread or significant instances of payments that were not warranted. Additionally, Stage 2 certification applies stricter tests of EHR capabilities for meaningful use and quality measure reporting.

Self-attestation is a feature of healthcare billing in general, and in our experience providers take their obligation for accuracy very seriously. Although clear safeguards must be in place, we do not want to undermine the incentive nature of the program or create unjustified burdens on providers.

We also note that we have not seen definitive information on "data blocking," as alluded to, but we do understand the concerns being raised and believe that Stage 2 requirements will substantially mitigate

[3] http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Nov/International-Profiles-of-Health-Care-Systems-2012.aspx

this issue. We are also addressing this concern in the work we are doing to create an EHR developer code of conduct. Finally, we would also point out that EHR vendors are not government contractors, as is suggested in the discussion in this section of the white paper, and were not intended to be treated as such. For example, payments go to providers and not to vendors.

4. **Patient Privacy at Risk**

The EHR Association takes seriously the privacy, security, and confidentiality of protected health information so we appreciate your consideration of this important topic.

Overall, we believe that the combination of HIPAA requirements, which are incorporated by reference into meaningful use, as well as the technical security requirements built into product certification, provide an appropriate approach to privacy and security in the EHR incentive program. Moreover, HIPAA provisions fully apply to providers whether they pursue meaningful use or not.

5. **Program Sustainability**

We recognize that the end of the federal incentives to adopt EHRs will shift a burden back onto providers, but we are confident in the larger value of EHRs as well as the ability of the market to generate innovative and cost effective solutions.

With respect to Stage 3 meaningful use, we believe that this and later stages should focus on building on the solid foundation established in Stage 2 and not require significant, new meaningful use capabilities and associated certification changes that will require major EHR upgrades. Such certification-driven upgrades would add significant complexity, unnecessary costs, and burden on EPs, EHs, and vendors without a corresponding value.

In our comments to CMS and ONC on the Policy Committee's proposed approach to Stage 3, we emphasized the need to learn from Stages 1 and 2; to allow sufficient time (i.e., 18 months) between when the Stage 3 Final Rules and associated specifications and supporting documents (e.g., certification test methods, quality measure specifications, and key FAQs) are available and the new stage starts. Given timing realties, we urge that CMS and ONC not start Stage 3 for at least three years after the start of Stage 2. We agree with CMS that issuing a Stage 3 proposed rule this year would be premature. In our experience, the current proposed timeline will not provide adequate time for CMS and ONC to develop all of the needed materials at a sufficiently high level of quality; for vendors to fully evaluate the hundreds of pages of regulation and supporting documents, then develop, test and certify the software; and for providers to install, then implement the software and become meaningful users.

We do not favor any halt in meaningful use payments given current and anticipated provider investments, as we continue our significant work to support our customers' Stage 2 needs as they continue to adopt new and innovative approaches to care delivery with the assistance of EHR technology. We do agree with the value of harmonizing and simplifying requirements across multiple federal programs, such as for quality reporting, to reduce costs to providers. The complexity and overlap of these programs makes it extremely challenging for both vendors and providers to achieve needed success.

In sum, the meaningful use incentive program should be maintained, with a more focused emphasis on the initial goals of outcomes improvements as well as responsiveness to the evolving market. Such a focused

approach will enable accurate, cost-effective, and efficient certification processes to allow EHR developers and their provider customers to devote time and resources to the highest priority efforts for patients, their families, and the nation's healthcare system. We are committed to continued collaboration with our customers, ONC and CMS, and other stakeholders to refine and improve the program and its administration to ensure that it serves the intended goal of achieving the promise of health IT as a key enabler in the transformation of the healthcare system.

Conclusion

We again thank the Senators for authoring a white paper on such an important topic and for articulating areas of concern. We share a common goal of effective expenditures of federal funds and for an interoperable, digitized healthcare system.

On behalf of the Association, we appreciate the opportunity to provide feedback and hope to serve as a positive resource in moving our nation forward in the transformation of healthcare delivery. To that end, we offer our ongoing support and perspective as you consider these issues.

Sincerely,

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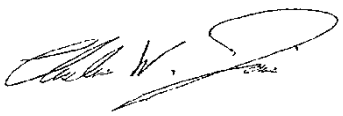

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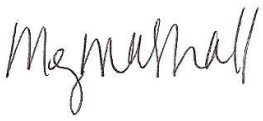

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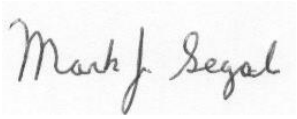

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About HIMSS EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of more than 40 companies that supply the vast majority of operational 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 the Healthcare Information and Management Systems Society (HIMSS). Membership in the Association is open to HIMSS corporate members with legally formed companies designing, developing and marketing their own commercially available EHRs with installations in the US. For more information, visit http://www.himssehra.org.