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November 12, 2013

The Honorable Max Baucus
Chairman, Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Dave Camp
Chairman, Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Sander Levin
Ranking Member, Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member, Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Baucus, Chairman Camp, Ranking Member Levin, and Ranking Member Hatch:

On behalf of the more than 40 member companies of the Electronic Health Record (EHR) Association, we would like to respond to the Committees' request for comments on your proposal to permanently repeal the Sustainable Growth Rate (SGR) formula payment system. We strongly support the need for a permanent replacement for the SGR and for its replacement with a system that will focus on the value (i.e., quality and efficiency) of services provided by physicians to Medicare beneficiaries and applaud the members for tackling such a critical subject in this challenging political environment.

We generally support the broad approach outlined, especially the focus on shifting to value-based payment approaches and using quality measures that are consistent

across federal programs and, as feasible, developed and/or supported by the physician community. We offer several comments for your consideration.

The Role of EHRs
Given the critical role that electronic health records (EHRs) will play in enabling physicians to participate in each element of the new value-based payment model (VPM) as well as advanced Alternative Payment Models (APMs), we urge Congress and the federal government to engage with EHR suppliers and the broader health information technology (HIT) community before and during implementation of the new approach to physician payment to help prepare for and ensure best use of technology in initial and later phases.

We envision that the availability of EHRs to assist physicians in each of the four categories of the VBP (Quality, Resource Use, Clinical Practice Improvement Activities, and EHR Meaningful Use) will be very high as this new program is implemented. Physician adoption of EHRs is growing rapidly, with 71.85% of physicians having adopted EHRs as of 2012 according to the National Center for Health Statistics, up from 57% in 2011.[1] Similarly, a recent report from the Commonwealth Foundation found that 69% of primary care physicians used EHRs in 2012, up by 50% from 46% in 2009.[2]

Most EHRs have robust capabilities in clinical quality measure reporting and clinical practice improvement. Such EHRs will also support both measurement and attainment of resource use goals.

The accelerated and meaningful use of EHRs with these capabilities therefore positions EHRs to be a critical tool in enabling a new value-based payment system, including growing use of APMs, all of which are founded on data and the measurement of quality and efficiency, and we appreciate the members' recognition of the current and anticipated value contributed to the EHR Incentive Program. We also note that EHRs can be used to provide near real-time feedback to physicians on the outcomes of their services, months sooner than is feasible with reporting by CMS or another agency.

General Approach to Quality Measures
With respect to quality measures and quality reporting, the Association strongly supports alignment of quality measures and reporting requirements, especially those intended for use in EHRs. It is critical that the alignment of these quality measures is consistent across federal and private sector programs, and developed through a standard set of validated tools and data sets. We well recognize the potential importance of new measures developed by physician organizations. At the same time, we urge that as much value as possible be derived from the existing set of physician-focused quality measures and that new measures be developed using the set of tools and standards that have been developed in recent years by the National Quality Forum (NQF), the National Library of Medicine (NLM), CMS, ONC, and standards organizations.

Fundamentally, measures must be developed so they are suitable for implementation in EHRs and consistent with, *not additive to*, physician workflow. Measurement and quality reporting should build on data already in the patient record and not drive clinical workflows for the sake of measurement. Finally, to the extent possible, quality measures should be aligned with opportunities identified as having the greatest potential for improvements in quality and efficiency. For these reasons, we support using the NQF and similar processes to validate and endorse measures. We also appreciate the

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[1] Hsiao CJ, Hing E. Use and Characteristics of Electronic Health Record Systems Among Office-based Physician Practices: United States, 2001-2012. NCHS data brief, no 111. Hyattsville, MD: National Center for Health Statistics. 2012.

[2] 2 S. Thomson, R. Osborn, D. Squires, and M. Jun, International Profiles of Health Care Systems, 2012, The Commonwealth Fund, November 2012

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provision in the draft legislation that calls for the Secretary to coordinate selection of quality measures for this purpose with existing measures and requirements.

Overall, CMS and ONC should continue to invest in quality measure alignment, infrastructure, and standards. Building on the foundation of Stage 2 of the EHR Incentive Program, and in order to validate this process and its results, the process must allow the time needed to establish the necessary standards and quality measures, perform field testing, and ensure collaboration among measure developers, providers, and vendors during measure development. The time required to do this properly should not be underestimated.

In choosing both measures and measure reporting approaches, we urge that final SGR-replacement legislation and its implementation focus on use of a consistent set of clinical quality measures that are eligible to be used to satisfy both PQRS and Meaningful Use starting in 2014. Given the importance of EHR-based measurement and reporting, it is essential that the measures used, especially at the start of this new program, are suitable for electronic measurement and reporting through EHRs.

We also urge, where multiple reporting approaches are available, that measures are harmonized to reduce the burden on physicians and EHR developers, minimizing potential confusion and wasted or duplicative efforts.

Clinical Practice Improvement Activities
We applaud your focus on Clinical Practice Improvement Activities and APM(s), as well as the recognition of the role of patient centered medical home in provision of such activities. We agree with the Committees' approach in this area. Because many of these activities benefit from or rely on EHRs and other HIT, we urge that the Congress and the Administration consult early and extensively with HIT developers in the development of specific requirements so that program requirements rely on capabilities that can reasonably be made available in the market place within needed time frames.

Other Quality Measure-Related Recommendations
In addition, we urge that the final SGR replacement reflect the following recommendations for ONC and CMS actions:

- Electronic clinical quality measures (eCQMs) should be developed "from scratch", versus reusing paper-based measures; and they should undergo feasibility testing during development.
- eCQMs should undergo a rigorous test process prior to inclusion in federal programs, such as the EHR Incentive Program.
- Collaboration among the measure developers, providers, EHR vendors, and federal agency program staff should be part of the measure development, validation, and implementation process.
- Any new quality measures should focus on measures that have a high level of value for all stakeholders and are aligned across other federal program requirements.
- We support the proposal to allow some flexibility in payment and reporting options, but we urge that key elements, such as a use of quality measures, have consistency across different options and that care is taken to ensure that the variability of reimbursement options can be effectively managed by CMS and providers.
- It is important that CMS and other involved agencies have the appropriate funding and technology in place to aggregate and allow for prompt analyses of quality and resource measures and application of adjustments as close as possible to the year in which results are used for those adjustments.

Meaningful Use
We generally agree with the shift of the EHR Incentive Program penalties into the new VBP system and the general integration of the Incentive Program into the framework of VBP. The initial weighting of 25% for meaningful use also makes sense but careful consideration should be given as to the proposed reduction of the weight for meaningful use to 15% once adoption hits 75%. It may be that, given the importance of EHR use for the overall program, the meaningful use weight should remain at 25%. We would also suggest that, if the proposed approach is taken, that the focus of the 75% trigger should be adoption of certified EHRs rather than achieving meaningful use.

In order to fully evaluate the impact of this proposal regarding EHR non-meaningful use penalties it will be important to compare the likely impact of non-meaningful use on the actual bonuses and penalties to be paid, as well as the importance of EHR use to achieving other VBP thresholds, to ensure that the new program continues to provide appropriate incentives for EHR adoption and meaningful use.

Finally, given the shift in focus for meaningful use, elimination of meaningful use-specific penalties, and the general integration into the overall VBP program, we urge that the Congress and the Administration take a very focused and prioritized approach to Stage 3 of the Incentive Program, to allow technologies to advance that enable VBP, such as those that support population health management, care coordination and quality improvement. The latest approach under consideration by the HIT Policy Committee would add a number of new meaningful use and especially certification requirements, not all of which directly support providers participating in a VBP program. We also urge thoughtful consideration in regard to timing of Stage 3 in order to avoid overly burdening providers.

With the shift in 2016 (or as we understand more likely 2017) to Stage 3, including the requirement to use a new "edition" of certified EHR technology for all participating physicians regardless of their meaningful use stage, shifting to the new VBP program and Stage 3 at the same time could be quite disruptive and undermine the prospects for initial VBP success. Indeed, with the inclusion of meaningful use into this new overall VBP program, we suggest that the overall expectation of moving through a continuous set of stages be revisited, with the recognition that market forces will drive future product functionality as physicians have the need to succeed in VBP and APM programs. Moreover, with more and more physicians in such programs, and the very robust levels of functionality in the Stage 2/2014 edition certified EHRs, as the new VBP program rolls out, careful consideration should be given to defining meaningful use for all physicians engaged with VBP or an advanced APM using the approach proposed for APM participants in which meaningful use is defined as use of a certified EHR.

We also urge that the Congress give explicit attention to physician specialties for which CMS has already acknowledged that the current meaningful use and certified EHR approach does not work well (e.g., radiology, anesthesiology, and pathology), those granted hardship exceptions, and non-physician providers not eligible for the Medicare EHR incentive program.

Registries
With respect to the proposed use of data from specialty registries that meet requirements established under Section 1848(m) (3) (E), we urge that care be taken here, especially with these data used as a partial basis for payment. Clearly, there are potential benefits in allowing third party entities to report quality data to CMS on behalf of physicians and other professionals. For example, this approach may ease the burden of reporting by offering additional options for submitting quality data that could potentially meet multiple goals and federal and non-federal program requirements.

Along with the potential benefits of allowing third party entities to report quality data to CMS, however, are risks that could be mitigated by implementing consistency across all organizations that submit

quality data to CMS on behalf of physicians and other eligible providers (EPs). For example, data should be consistent with any other quality data being collected. In order to ensure consistency in the data that is collected and the quality of that data, it would be essential for third party entities to meet the same standards to which current reporting entities are held. These standards include using the same measure specifications, alignment of reporting formats and standards, certification/qualification programs, and reporting and data submission timelines. Consistency must also include the measure result given the same underlying data, as variation of the end measure calculation can result from different versions of measures. Finally, we support the use of one standard for all electronic quality measure data submission.

We thank you for your leadership and stand ready to work with the Committees on helping to refine and implement these proposals, specifically where our software and services will be fundamental to their success. Thank you for your consideration.

Sincerely,

Michele McGlynn
Chair, EHR Association
Siemens
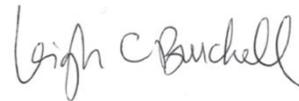
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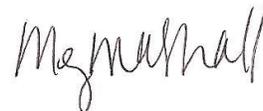**HIMSS EHR Association Executive Committee**

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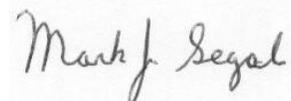
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About HIMSS EHR Association

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). For more information, visit www.ehrassociation.org.