Statement of the College of Healthcare Information Management Executives

House Committee on Ways and Means
Subcommittee on Health

Hearing on “Current Status of the Medicare Program, Payment Systems, and Extenders”
1100 Longworth

May 18, 2017

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit a statement for the record for the May 18, 2017, hearing entitled, “Current Status of the Medicare Program, Payment Systems, and Extenders.” We appreciate the committee’s leadership and continued interest in the transformation of the nation’s healthcare system and federal payment programs to better meet patient needs in the 21st Century.

CHIME is an executive organization serving more than 2,300 chief information officers (CIOs) and other senior health information technology leaders at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business technology systems facilitating healthcare transformation. Our organization is a strong proponent of health IT and its ability to enable improvements in health care quality, increase affordability and improve healthcare outcomes.

Enabling a Digital Infrastructure to Foster Delivery System Reform

Since enactment of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), the healthcare industry has made a significant shift in the way technology is used to treat and engage with patients. The prolific adoption of electronic health records (EHRs) and other health IT resources by clinicians and patients will pay dividends as the nation’s physicians transition to value-base care.

The shift from a fee-for-service model is not to be understated; technical challenges and opportunities associated with generating reliable performance data to determine reimbursement will be a challenge with existing technology. A robust digital health infrastructure — built around highly functional and user-friendly EHRs — is key for physicians and hospitals to be successful in new payment models, including the pathways created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). To ensure providers have the technology necessary to enable a value-based, outcome-driven care environment, the committee should consider actions to:

1. Create parity for both eligible providers (EPs) and eligible hospitals (EHs) by removing the existing pass/fail construct and add additional flexibility under the Meaningful Use program.

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2. Delay implementation of Stage 3 of the Meaningful Use program and Stage3-like measures in the Merit-based Incentive Payment System (MIPS) program indefinitely. Related to this, we request providers not be required to move to 2015 Edition CEHRT.
3. Reduce the burden of quality measure reporting for providers by streamlining reporting redundancies and refrain from requiring data collection and submission on measures that do not directly advance patient care.
4. Promote standards-based interoperability.

Parity for Physicians and Hospitals in the Meaningful Use Program

As the Centers for Medicare and Medicaid Services (CMS) allows a regulatory framework for MACRA to evolve and revisits the regulatory burden inflicted on providers from the reporting requirements of other Medicare payment programs, it is imperative that a comprehensive review be conducted on the health information technology mandates that are in conflict across federal programs.

The Meaningful Use Program

CMS offered Medicare physicians participating in MACRA some flexibility under the Advancing Care Information (ACI) performance category – which was previously known as Meaningful Use - effectively removing the all-or-nothing program construct. However, the agency has stated that the same authority does not enable similar changes for hospitals. The current pass/fail approach does more harm than good; it jeopardizes the hard work and investments that well-intended providers have made to meet the program's requirements and risks them incurring a financial penalty, even after making a good faith effort to be successful in the program.

While the removal of the pass/fail construct for Medicare EPs is welcome, leaving it in place for hospitals has introduced a level of complexity that will be very difficult for providers and CMS to manage. This is especially important as payment models evolve to necessitate greater coordination between hospitals and physician offices – delivery system reforms encourage a longitudinal approach to patient care, rather than episode by episode, and conflicted requirements are impeding progress. Further, having a different set of program expectations for different providers could jeopardize attempts by Accountable Care Organizations (ACO) or bundled payment models to better coordinate care. It's imperative that CMS streamline the Meaningful Use program for hospitals and physicians and remove the pass/fail construct for all providers.

The committee should encourage CMS to indefinitely delay the mandate for Meaningful Use program participants to comply with Stage 3 measures, which is currently slated for January 1, 2018. Concerns have been raised across the provider community about unrealistic timeframes and the difficult-to-meet requirements laid out in Stage 3 of the Meaningful Use program, as well as with the related requirements under MIPS. Since Meaningful Use began in 2011, various program requirements and stages have been delayed repeatedly, largely due to the program's complexity. Providers and vendors have experienced a constantly shifting regulatory environment creating ongoing uncertainty and needless burdens.

Providers are still acclimating to Modified Stage 2 measures and transitioning to the MIPS program, and we believe more time is needed at this stage to offer stability to the clinicians using the technology and to enable innovation in the marketplace. The measures that accompany Stage 3 of the Meaningful Use program are predicated on interoperability, being able to easily exchange and use data, which is not common place today. Further, the existing timelines, which require providers to implement 2015 Edition CEHRT by January 1, 2018, do not take into account the important improvements included in the 21st Century Cures Act. Providers will not have the

opportunity to benefit from several provisions aimed at improving the use of EHRs, including efforts to reduce the regulatory burden and improvements to the usability of CEHRT.

2015 Edition CEHRT

CMS has also insisted that providers, if participating in at least 13 different programs - including alternative payment models such as Comprehensive Primary Care Plus (CPC+), Next Generation ACO and other programs such as Inpatient Quality Reporting (IQR) and Acute Myocardial Infarction (AMI) program - need the 2015 version of Certified Electronic Health Record Technology (CEHRT) for use by January 1, 2018. Complicating matters is the fact that only approximately two percent of EHRs (72 individual EHR modules[1]) have been certified by the Office of the National Coordinator for Health Information Technology (ONC) to the 2015 edition compared with the number which have been certified for the previous version (3,724) now in use.

CMS acknowledged the limited number of certified products in the Inpatient Prospective Payment Systems (IPPS) Rule and granted a 90-day reporting period for Meaningful Use program participants in 2018, but still mandated that 2015 CEHRT be in place by January 1, 2018 for quality measurement for hospitals, therefore not allowing any leeway in when the certified technology must be operational for all Medicare-billing hospitals or else they face a monetary penalty. CMS discussed a willingness to revisit the timeline for 2015 CEHRT use, and it is vital that the committee weigh-in to ensure the provider community not be unnecessarily forced to use technology that they have either not been delivered in a timely fashion or had properly tested and optimized just to meet a federal government mandate. Without a timeline, change providers face rushed implementations which may jeopardize patient safety coupled with the potential for substantial financial penalties.

Improving Quality Measurement

The future of value-based reimbursement is contingent on the ability to improve performance. Congress should prioritize a unified strategy for measuring, capturing and communicating quality in healthcare. Efforts have been underway since before passage of HITECH to devise quality indicators that can be electronically captured in clinical workflow, yet organizations still must deploy sizable staffs for manual abstracting as electronically generated measures are inaccurate and unreliable. A study published in *Health Affairs*[2] last year showed medical practices in just four specialties spend an estimated $15.4 billion each year reporting whether they are meeting their quality targets, which on average costs them $40,069 per physician or 785 manpower hours.

Currently, providers are required to report clinical quality measures (CQMs) to several public and private entities. Individual healthcare delivery organizations submit more than 20 reports across federal, state and private sector programs for various CQMs each month. Hours of work and expertise are required to comply with these reporting demands and such burdens are exacerbated by a lack of technical harmonization. In other words, even when the same CQMs are used among different programs, they tend to require different technical specifications or values to be reported. The goal should be to eliminate duplicative quality measures and reporting requirements which would reduce healthcare costs and allow clinicians to focus more attention on patient care.

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[1] Certified Health IT Products List, Office of the National Coordinator for Health IT, https://chpl.healthit.gov/#/search

[2] Casalino, Lawrence P., David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziehler, Meghan M. Wong, and Todd B. Evenson. "US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures." Health Affairs 401-406 35.3 (2016). Http://healthaffairs.org/. Mar. 2016. Web. 16 Mar. 2016.

The successful administration of MACRA and other Medicare programs will hinge on providers' and CMS' ability to accurately capture and meaningfully measure the quality of care delivered to the nation's patients. Efforts to reduce provider burden by streamlining reporting redundancies must be a priority and requiring data collection and submission on measures that do not advance patient care must cease. Access to real-time, actionable data will be critical for success in the MIPS and alternative payment models (APMs), thus we must ensure that policies are supported to enhance the capabilities of EHRs in this area and free vendors to pursue innovative solutions that best meet provider and patient needs.

Promoting Interoperability

Improving quality of care and lowering costs will be contingent on the free flow of patient data across care settings, a must for delivery system reform. Unfortunately, today patients and care providers are missing opportunities to improve people's health and welfare when information about care or health status is not easily available. Notably, robust information exchange and nationwide interoperability can flourish only once we can confidently identify a patient across providers, locations and vendors.

Patient Identification for Interoperability
The concept of a longitudinal healthcare record, that necessitates interoperability, should reflect the patient's experience across episodes of care, payers, geographic locations and stages of life. It should consist of provider-, payer- and patient-generated data, and be accessible to all members of an individual's care team, including the patient, in a single location, as an invaluable resource in care coordination. Without a standard patient identification solution, the creation of a longitudinal care record is simply not feasible.

Congress acknowledged the lack of a national solution to identify patients is an interoperability and patient safety issue in the FY17 Omnibus Committee Report[3]. Congress then went on to clarify that the ONC and CMS can provide technical assistance to private-sector patient identification efforts. Efficiencies in care coordination, as intended by Congress in the HITECH Act, would not only be enhanced by a national strategy for patient identification but would also result in savings across the healthcare continuum.

Standards-based Interoperability
While a focus on data standards may seem overly simplistic, a more defined technical infrastructure is needed to catalyze innovations in digital health. We recognize the work underway at the ONC to tackle these challenges, nonetheless barriers remain and maintaining the status quo will stifle future progress. It's imperative that the ONC continue to leverage relationships with the private sector to capitalize on the progress made to date across the industry.

Further, insofar as certification is the method the Department of Health and Human Services (HHS) is using to achieve adherence to technical standards and specifications, the form and function of certification needs to adapt. ONC's Certification Program must be considered as a primary vehicle for enhancing interoperability and care coordination, thus acknowledging the voluntary certification as the only current means to enforce technology developers' compliance to federal law.

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[3] Committee Report, H.R.244, Consolidated Appropriations Act 2017 (115th Congress) https://www.congress.gov/114/crpt/hrpt699/CRPT-114hrpt699.pdf

There is great potential to improve patient care and reduce healthcare costs, through care coordination, in an interoperable healthcare ecosystem. The 21st Century Cures Act[4] declared Congress' interest in an interoperable health IT infrastructure. The committee should encourage the ONC to ensure that the directive to focus on standards and implementations specifications included in the statute is realized. Standards-based interoperability should be a top priority for the ONC as they establish and set the agenda for the new Health Information Technology Advisory Committee. Understanding how the lack of ubiquitous interoperability and meaningful data exchange is impeding care delivery and making necessary policy recommendations, should be an area of work for the new advisory committee.

Enabling Innovation in Healthcare Technology

A great deal of innovation is underway to develop population health tools and other new technologies that will be critical for advancing provider success in APMs. CMS must avoid a heavy-handed approach to determining what technologies providers must use. Further, the HHS, more specifically CMS in coordination with ONC, should take an approach that allows innovation to continue to flourish rather than prematurely try to certify these innovative technologies.

As the committee monitors the implementation and administration of Medicare payment policies and programs, we urge committee members to ensure providers have access to technology necessary to facilitate their success in new payment models and drive care improvements for patients. Further, the committee should encourage CMS to pursue reasonable policies that will reduce provider burden, facilitate greater care coordination, and direct the maximum amount of attention on the care delivered to patients. The committee should instruct the Administration to consider lessons learned and incorporate provider input on how to ensure the technology clinicians need and patients want is available and appropriately supported by Medicare prorgams. A focus on improved outcomes (rather than process measures), facilitated by interoperability, will position providers for success in new payment programs while enabling the delivery of better care to patients.

[4] The 21st Century Cures Act (HR 34), 114th Congress. https://www.congress.gov/114/bills/hr34/BILLS-114hr34enr.pdf