Statement of the College of Healthcare Information Management Executives

House Committee on Energy and Commerce
Subcommittee on Health

Hearing on "Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms"
2322 Rayburn

March 17, 2016

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit a statement for the record for the March 17, 2016, hearing entitled, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms." We appreciate the committee's leadership and continued interest in the transformation of the nation's healthcare system to better meet patient needs in the 21st Century.

CHIME is an executive organization serving more than 1,800 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 that are 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 under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA.)

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 MACRA. To ensure providers have the technology necessary to enable a value-based, outcomes-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.

2. 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.
3. Promote standards-based interoperability.

Parity for Physicians and Hospitals in the Meaningful Use Program

As the Centers for Medicare and Medicaid Services (CMS) develops a regulatory framework for MACRA, officials have alluded to forthcoming flexibility for physicians in the Meaningful Use program, including a change to the pass/fail or "all-or-nothing" construct. However, the agency has stated that the same authority does not enable similar changes for hospitals. The 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.

The agency's consideration of removing the pass/fail construct for EPs is welcome, however, leaving it in place for hospitals will introduce 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. Further, having a different set of program expectations for different providers could jeopardize attempts to 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.

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*[1] this month 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 in turn would reduce healthcare costs and allow clinicians to focus more attention on patient care.

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[1] 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 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 Merit-based Incentive Payment System (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.

While a focus on 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 Office of the National Coordinator for Health IT (ONC) to tackle these challenges, nonetheless barriers remain and maintaining the status quo will stifle future progress. The federal government should continue to drive standards identification and adoption in the following nine categories: patient identification, resource locators (e.g. provider directories), terminologies, detailed clinical models, clinical data query language based on the models and terminology, security (standard roles and standards for naming types of protected data), application program interfaces (APIs), transport protocols and expressing clinical decision support algorithms. It's imperative that ONC continue to leverage relationships with the private sector to capitalize on the progress made to date across the industry.

Insofar as certification is the method 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 that the voluntary certification as the only current means to enforce technology developers' compliance to federal law.

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 Department of Health and Human Services (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 MACRA policies, we urge Members to ensure providers have access to technology necessary to facilitate their success in new payment models and drive care improvements for patients while ensuring CMS pursues reasonable policies that will reduce provider burden, facilitate greater care coordination, and direct the maximum amount of attention on the care delivered to patients.