Alliance of Specialty Medicine

Sound Policy. Quality Care.

June 30, 2015

The Honorable Lamar Alexander, Chairman
The Honorable Patty Murray, Ranking Member
Senate Health, Education, Labor & Pensions Committee
428 Dirksen Senate Office Building
Washington, DC 20510

RE: Senate HELP Committee Workgroup and Hearings on HIT

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the undersigned organizations of the Alliance of Specialty Medicine, we are writing to express our appreciation for the Senate Health, Education, Labor and Pension (HELP) Committee's decision to establish a bipartisan workgroup and hold a series of hearings on potential solutions to achieve the promise of health information technology (HIT). The Alliance is a coalition of national medical societies representing specialty physicians in the U.S. and is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. Our members recognize the value of HIT in regards to improving the quality and efficiency of care, and we support the goal of establishing a national HIT infrastructure. Nevertheless, considerable barriers to widespread adoption of HIT remain, including the high cost of implementation and maintenance; a paucity of electronic health record (EHR) functionalities, as well as Meaningful Use measures and objectives, that are pertinent to specialists and their patients; and grossly insufficient interoperability between systems. The promise of HIT, and electronic health records (EHRs) in particular, cannot be realized until policies are adopted to address these barriers and our nation's HIT infrastructure is strengthened. Until such policies are in place, physicians should not be held accountable for increasingly difficult federal reporting mandates and Stage 3 of Meaningful Use should be delayed.

Below, we elaborate on some of the most significant impediments to meaningful adoption and use of EHRs.

Interoperability

It is absolutely critical that the federal government adopt more precise standards to ensure the seamless exchange of health information between EHR systems, settings of care, and data collection tools (e.g., between EHRs and registries). Since past experience has proven that standards, alone, are inadequate, it is equally critical that mechanisms are adopted to enforce these standards and to ensure that interoperability remains the responsibility of EHR vendors. Interoperability is the cornerstone of a well-functioning HIT infrastructure and without it, the value and efficiencies of EHRs will never be realized. Even where interoperability does currently exist, the onus has been shifted to providers, who are often burdened with the hefty cost of ensuring that their EHR systems can talk to each other, to other systems, and to other data sources and

for making regular updates to their systems to ensure ongoing interoperability. We urge Congress to mandate that EHR vendors adopt interoperability standards as a condition of receiving federal certification, but to also enact policies that ensure that added costs related to this critical functionality is not disproportionately shifted to EHR users.

Addressing the Unique Needs of Specialty Medicine

In addition to the lack of interoperability, one of the biggest challenges facing specialty medicine is that current HIT-related policies continue to fail to recognize the heterogeneous nature of physicians, their practice settings, their patient populations, and their EHR needs. Many specialists have adopted EHRs, but still choose not to participate in the EHR Incentive Program due to a lack of specialty-specific measures and increasingly limited reporting options that aim to hold physicians to a uniform set of standards rather than offering greater flexibility that recognizes the diversity of practices. Adding to these challenges is the fact that vendors often seek to avoid the added expense of extensive customization, focusing instead on building models based solely on federal program requirements. This results in systems that only collect information on a limited set of measures (typically primary care-focused) and offer functionalities that are not relevant to specialists. Even in situations where custom models can be built for specialists, the costs are often prohibitive and the functionalities often do not count towards satisfying federal mandates.

In light of these ongoing obstacles, the Alliance was disappointed to learn through the EHR Incentive Program Stage 3 proposed rule that CMS intends to move toward a single, uniform definition of meaningful use that all providers would be required to adhere to by 2018, regardless of their prior participation in the program. While we support efforts to minimize physician reporting burden, this proposal unfortunately perpetuates the problematic one-size-fits-all approach that has long plagued this program and has made it largely irrelevant to specialists. We believe that offering physicians a wider assortment of objectives, measures and reporting options would result in more meaningful participation and ultimately, encourage more widespread adoption of EHRs in a manner that is relevant and truly impacts quality.[1]

Related to this strategy, CMS also proposes to abandon what has traditionally been a staged approach to meaningful use. The Alliance opposes this proposal in favor of a more gradual approach to recognizing advanced uses of EHR technology to improve patient care. This approach should preserve incremental sets of requirements that reflect a physician's level of experience with meaningful use of EHRs over time. We also oppose CMS' proposal to eliminate the 90-day reporting period for first year participants. Traditionally, all new participants to the program have been given the option to report for less than a year to allow them to get acclimated to the program, and this exception should be extended into the future.

Finally, the Alliance is equally concerned about the all-or-nothing nature of the EHR Incentive Program. Under this approach, physicians who have made a true commitment to meaningful use may still be penalized and unrecognized for their investment if they fail any single objective. This is a major disincentive to specialists who already have major concerns about the relevance of this program. We urge Congress to put pressure on CMS to modify this long-standing policy.

[1] *In its May 2015 comment letter to CMS in response to the Stage 3 proposed rule, the American Urological Association (AUA) supported a single set of measures and objectives for Meaningful Use in 2018.*

Data-Driven Policymaking

We remind Congress that only a small fraction of physicians have been able to satisfy Stage 2 to date and that a significant portion still have not participated in the program at all. With such low participation rates, we question whether these are sufficient data to accurately guide policymaking for Stage 3 and beyond. Making changes to the program too quickly and without a sufficient evidence base could result in misguided policies that further discourage specialist engagement and erode the quality of patient care. We urge federal policymakers to delay the transition to Stage 3 until CMS, ONC and the public have had a chance to collect more extensive data and more carefully evaluate barriers to participation related to prior stages of meaningful use.

Clinical Data Registries

The Alliance strongly supports the expanded use of clinical data registries to improve the quality and safety of patient care. Quality measure data collected through these registries are often more relevant, clinically appropriate, and actionable for specialists than the measures currently available under federal quality reporting programs. Alignment of registry participation with the EHR Incentive Program is one way to help facilitate strategic health information exchange and more focused quality improvement, while reducing the reporting burden on the physician community. Allowing specialists to participate through registries that are validated, relevant, and developed and run by specialists will result in more meaningful and widespread participation in federal quality improvement programs.

However, better standards for bidirectional data exchange between EHRs and registries is needed before physicians can take full advantage of clinical data sources. The most significant current barriers to integration of EHR data in registries is EHR vendor refusal to share data with registries or charging excessive fees for such access. As a result of the proprietary nature of EHR products, physician practices are forced to manually enter EHR data into a registry. This contradicts the underlying goals of electronic health information exchange and is particularly challenging for solo and small practices, who lack the resources to hire additional staff for data entry and therefore cannot take advantage of these valuable combined data sources.

Concluding Remarks

Although the Alliance recognizes the value that widespread adoption of HIT could bring to our health system, policies enacted to date are unsustainable over the long term. If EHR adoption is increasingly challenging and expensive, and if EHR products are increasingly irrelevant to specialty practice and disruptive to patient care, then physicians will be even more reluctant to use them and their value as a critical tool for enhancing the quality and efficiency of care will go unrealized. Under a worst-case scenario, the misapplication of these tools to the practice of medicine could result in the unintended consequence of even lower quality care and perhaps even compromise patient safety.

Although Stage 3 is the final stage of the EHR Incentive Program, EHR meaningful use will remain a significant component of the Medicare Incentive Payment System (MIPS), authorized under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. In fact, multiple aspects of MACRA will depend largely on a well-functioning national HIT infrastructure. If this significant piece of the puzzle is not fixed, we will simply repeat the same mistakes of the past and any potential gains from this long-awaited fix will go unnoticed.

The Alliance strongly urges Congress to put pressure on CMS and ONC to make interoperability a top priority; to make federal reporting mandates related to EHR meaningful use more flexible so that they recognize the needs of specialists, the diversity of practices, and varying physician experience with EHR adoption; and to more carefully study current challenges to more widespread use of these tools before setting future policies that further incorporate HIT into the practice of medicine.

The Alliance thanks the Committee for shedding light on this critical issue and looks forward to working with you to achieve a nationwide interoperable HIT infrastructure that is both meaningful to providers and beneficial to patients.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists
Society for Excellence in Eyecare