May 16, 2013

Submitted Electronically to HealthIT_CommentPeriod@thune.senate.gov

The Honorable John Thune
United States Senator
511 Dirksen Senate Office Building
Washington, DC 20515

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
Washington, DC 20515

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 Thune, Alexander, Roberts, Burr, Coburn, and Enzi,

The undersigned consumer organizations are members of the Consumer Partnership for eHealth (CPeH) and the Campaign for Better Care (CBC). The National Partnership for Women and Families leads these two important coalitions collectively representing more than 150 consumer and patient groups dedicated to changing the way health care is delivered and financed. Further, CPeH is working to ensure that implementation of the HITECH Act result in higher quality, more patient-centered care, fewer disparities, and better outcomes for everyone.

We appreciate the opportunity to review and comment on "REBOOT: Re-examining the Strategies Needed to Successfully Adopt Health IT." Like you, we seek to advance health information technology in ways that measurably improve the lives of individuals and their families. Regardless of political allegiances, both lawmakers and their constituents on both sides of the aisle agree that despite the best efforts of deeply caring health professionals, our health care system is simply too expensive in both financial and human terms – for patients and providers alike. While the United States is home to the best doctors, clinicians, and treatments in the world, in terms of information technology, our health care system is behind every other major industry in our nation. Health IT is the essential foundation for both improving health outcomes for individuals and populations, as well as lowering costs. These goals simply cannot be achieved without it.

However, we cannot transform the entire nation's health information backbone on a dime. Congress was wise when it created the strategic, quickly phased approach as directed by the

HITECH Act, from 2009-2014 and beyond. Thanks to the visionary leadership of Congress, including your offices, the HITECH Act for the first time created a national strategy to transform a health care system that was generally mired in siloed, paper-based systems to one of electronic systems that allow critical health information to be available in real time, and enable the kind of coordination and communication that patients, families, and providers want and need. There is bipartisan agreement that we need to change the way we pay for health care in order to improve health outcomes and lower costs, but we cannot achieve payment reform using the information from claims and paper medical charts. Through the Electronic Health Record (EHR) Incentive Program (commonly known as Meaningful Use), Congress provided the nation with the necessary tools to transform American health care from the current fee-for-service model to one that rewards outcomes and quality care. Meaningful Use is just beginning to pay off – and it is only in its first, and by design, most basic stage.

Pausing or delaying the program is not the answer. To the extent that particular issues exist in interoperability, financing, oversight, privacy, or sustainability, we should not pause or delay the only mechanism the nation has for modernizing health care and spurring innovation. We should, however, routinely assess the program, and incorporate improvements. **Stage 2 implementation and Stage 3 rulemaking should remain on their intended trajectories, or even be accelerated.** Stage 2 offers many more benefits directly to patients and providers by focusing on information sharing, and Stage 3 offers more promise for improving care and lowering costs by focusing on using EHRs to improve outcomes. **These goals cannot and should not be compromised with delays or distractions.**

Interoperability

The white paper, like the HITECH Act, recognizes that interoperability is paramount to success, and we appreciate your commitment to this critical issue. When this effort began, systems were not interoperable for the most part, and we have covered incredible ground in the four years since the HITECH Act was enacted. Obviously we cannot transform the nation from a mostly paper-based siloed system to electronic interoperability in a few years**. Delaying Meaningful Use would stifle the very innovation and progress we need to make towards interoperability.**

Driven by Meaningful Use, numerous stakeholder committees are working diligently to bring together expertise on how best to implement this transition, including the development of standards necessary for interoperability and common requirements and functions that all certified EHR technology must incorporate. Prior to Meaningful Use, the development of the battery of standards and services needed to make interoperability easy and efficient was slow to non-existent. While experts had been working for decades to create standards and drive their adoption in the private sector, those well-intentioned efforts were tangled in a maze of competing standards in some areas, and a complete lack of standards in others. The Meaningful Use regulations and complementary Certification rules have been essential to lead standards development toward a common set of requirements for interoperability and creating interoperability at far greater and faster rates so that health information can be more uniformly collected and shared. This kind of federal leadership, in collaboration with the private sector in open and transparent ways, is critical to fostering innovation and achieving true interoperability.

Moreover, these efforts are working. There is interoperability among numerous systems. EHRs are instituted at the practice level, so already there is interoperability among doctors on each practice's or hospital's EHR, not to mention individual practitioners. Interoperability is not limited to large, advanced health care systems such as Kaiser Permanente and Geisinger Health System either. For example, Dr. Jennifer Brull of Kansas registered for the EHR Incentive Program in 2011 and was the first provider to attest in her state.[1] While Dr. Brull is a solo practitioner in a town of 2,000 individuals, her practice is a part of Post Rock Family Medicine, which comprises five separate practices. Despite being individual practices divided among three different towns, Dr. Brull and her colleagues share information through their interoperable EHR system.[2] Soon, Post Rock Family Medicine will join the Kansas Health Information Exchange, and Dr. Brull and her colleagues will be able to share information not only with other rural providers, but also with the larger medical systems in Kansas City, Wichita, and Topeka.

Currently, more than 73 percent of eligible providers and nearly 87 percent of eligible hospitals have already registered for the Meaningful Use program, signaling their intent to complete it and adhere to the minimal set of standards and functions the regulations on certified EHR technology require. *This substantially increased adoption will drive demand for interoperable systems.* Moreover, as these practitioners become Meaningful Users, they will not only be using certified, interoperable systems, but will be meeting Meaningful Use criteria that build unprecedented information exchange with pharmacies, labs, public health agencies and registries, unaffiliated providers, and most importantly, the patients, families, and caregivers themselves. This includes the Stage 2 criterion to share summary of care records for at least half of all transitions of care and referrals, at least ten percent of which must be sent electronically, and at least one of which must be with a recipient who has technology designed by a different developer than the sender.[3] It is the Meaningful Use program that is responsible for much of this rapid and vast improvement and progress. **We must leverage the program, not reboot it, to incorporate new learnings and continue progress.**

Costs

It is precisely because we share your desire to reduce the burden of health care costs that we believe the Meaningful Use program must be strengthened, not delayed. Allowing providers to share health information electronically helps avoid medical errors and unnecessary or duplicative services, thus reducing individual consumers' and the nation's costs and addressing one of consumers' primary frustrations with the health care system. Moreover, the Meaningful Use program addresses one of the largest drivers of our nation's health care costs: health care disparities.

The Joint Center for Political and Economic Studies estimated the cost of racial and ethnic disparities between 2003 and 2006 to be $1.24 trillion.[4] Health IT is an essential tool for

[1] Office of the National Coordinator. Health IT Success Stories. "Dr. Brull Shares the Benefits of EHRs in a Single Physician Practice." Available at: http://www.healthit.gov/profiles/preventative-care

[2] Post Rock Family Medicine. http://www.postrock.us/

[3] Office of the National Coordinator. Stage 2 Reference Grid: Meaningful Use Stage 2 and Correlated 2014 Edition EHR Certification Criteria. http://www.healthit.gov/sites/default/files/mus2_scc14_grid_2-1-13.pdf

[4] LaVeist TA, Gaskin DJ, Richard P. The Economic Burden of Health Inequalities in the United States. The Joint Center for Political and Economic Studies. September 2009. Available online:

reducing disparities in health and care. It enables providers to look at real-time data to assess how equitable their care is, whether certain patient groups have better or worse health outcomes, and it helps providers create strategies to improve quality of care for affected populations, while containing costs. It also empowers and facilitates more engagement of underserved populations in the health care system. **Delaying Meaningful Use would not only postpone the cost savings that come from reducing health care disparities, but also impede improved access and quality health care for all of our nation's citizens.**

As the white paper notes, EHRs are also changing the way that providers bill. EHRs allow providers to code their services more accurately and in more detail, creating the very database needed to assess quality, value, and comparative effectiveness, which is essential in order to transform our health care system from fee-for-service to one that rewards quality and outcomes. Similarly, EHRs create the very database and evidence needed to audit effectively and efficiently whether costs are reasonable and justified, or excessive or fraudulent.

Many of our best, evidence-based ideas to change the way we pay for and deliver care hinge on the availability and seamless exchange of health information to introduce efficiencies and cost savings, and to provide the kind of care that improves patients' health. They require measuring and rewarding value and quality over volume. But we simply cannot measure health outcomes or efficiency without EHRs and the structured evidence they make available. **Again, we cannot delay the Meaningful Use program and use of certified EHR technology, and instead must use these mechanisms to improve care delivery and address issues as they arise.**

Oversight

The white paper questions the strategy to allow providers to attest to meaningful use of certified EHR technology based on a provider's internal documentation. We shared those concerns initially as the first stage of the program was designed, but quickly learned that the capability of EHRs to submit automated and immutable reports of their use was extremely limited in Stage 1. This is changing as the program progresses and more functionalities are developed as a result of the certification process. In addition, as we advocated for, CMS and ONC are working diligently to audit and ensure program integrity. As you may know, ONC recently announced an increase in attestation auditing, and CMS recently published a second, more comprehensive audit guide and has begun pre-payment audits on "high risk" providers. CMS has also increased audits from five percent of hospitals and ten percent of physicians to 20 percent of hospitals and 40 percent of physicians. Moreover, CMS conducts a quarterly review of its audit processes over the Meaningful Use program, allowing assessment and audit increase if warranted.[5] We are delighted with this progress.

Advancing Meaningful Use and the certification of functions and standards that accompanies it is the best way to shift away from today's use of screen shots, self-reported data, and some limited EHR reporting. As the systems become more advanced and robust,

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http://www.jointcenter.org/publications_recent_publications/health/the_economic_burden_of_health_inequalities_in_the_united_states.

[5] Center for Medicare and Medicaid Services. EHR Incentive Programs Supporting Documentation for Audits. February 2013. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf

providers will be able to produce attestation reports with audit trails that are immutable. Delaying the Meaningful Use program, however, would interrupt these efforts and force us to continue to rely on survey attestation. We also note that delaying incentive payments in compliance with the Meaningful Use program would create or substantially exacerbate the very sustainability issues the white paper posits in a later section.

Patient Privacy and Data Security

Patient privacy and data security are critical components of ensuring trust and enabling private and secure health information exchange, and we therefore commend ONC for taking the initiative to ask the Institute of Medicine (IOM) to evaluate safety and privacy concerns regarding EHRs. When the Office of Inspector General (OIG) audited the health information security components of ONC's certification standards, ONC agreed with the OIG and addressed these issues with substantial privacy and security requirements built into both the certified EHR technology regulations and the meaningful use regulations released in September, 2012.[6] **This is exactly the kind of proactive planning and improvement that the white paper requests.**

The white paper also notes that it is important that both providers and consumers trust EHRs, and the evidence suggests that access to EHRs increases trust. Recently, the National Partnership for Women & Families conducted a national survey of nearly 2,000 Americans whose doctors used EHRs and those whose doctors still used paper records. The results showed that not only do patients (regardless of the type of record their physicians have) see value in EHRs, but that online access is correlated with enhanced trust. Patients with online access to their health information are more likely to say they trust their doctor and staff to protect their patient rights as well as feeling well informed about how their medical information is collected and used in the EHR system.[7]

Sustainability

Our current fee-for-service health care system is unsustainable, as evidenced by the yearly attempts to fix the Medicare Sustainable Growth Rate (SGR) physician payment formula. The Meaningful Use program is our linchpin to creating the kind of quality and outcomes-based health care system that our nation so desperately wants and needs. **Suspending Meaningful Use would only serve to keep us stuck in our current broken, unsustainable health care system.**

When the Meaningful Use program began, its effectiveness and sustainability were questioned. Many wondered if incentive payments would, in fact, drive EHR adoption and whether providers would be able to achieve Meaningful Use. In a 2010 Energy and Commerce Subcommittee on Health hearing on the Meaningful Use program, CMS officials projected a high-end estimate that 53 percent of ambulatory care providers would adopt EHRs by 2015.[8]

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[6] 77 Federal Register 54163, 54289-54290 (certified EHR technology regulations); 77 Federal Register 54396, 54002-54003 (meaningful use regulations).

[7] National Partnership for Women & Families. Making IT Meaningful: How Consumers Value and Trust Health IT. February 2012. http://www.nationalpartnership.org/site/DocServer/HIT_Making_IT_Meaningful_National_Partnership_February_2.pdf?docID=9783

[8] U.S. House of Representatives. Committee on Energy and Commerce. Subcommittee on Health. Hearing on "Implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009." July 27, 2010. http://democrats.energycommerce.house.gov/documents/20100727/transcript.07.27.2010.he.pdf

But as of April of this year – two years before the 2015 deadline – CMS data show that more than 73 percent of eligible providers have already registered for the program, signaling their intent to complete it. And nearly 49 percent have already successfully completed the first phase of either the Medicare or Medicaid incentive program. Moreover, of those who have attested, less than 0.1% were unsuccessful, indicating that providers are more than able to meet Stage 1 requirements.[9] Hospitals have been even more successful. Almost 87 percent of eligible hospitals have registered for the program and more than 77 percent are meaningful users today. What's more, of the hospitals that attested, all did so successfully.[10]

While some providers were utilizing EHRs prior to the Meaningful Use program, for these providers, Meaningful Use acted as a driver for the organizational and culture change so instrumental to improving care and reducing costs. For example, Vanderbilt University Medical Center (VUMC) had a homegrown EHR system since 2001. However, not everyone used it; doctors had built and were using their own clinical summary applications that were not interoperable with each other; and the workflow surrounding EHRs varied. At VUMC, Meaningful Use established standards for an improved EHR system that was interoperable between different departments and doctors and standardized work at 120 locations. Moreover, the 700 eligible providers attested as meaningful users for either the Medicare or Medicaid Meaningful Use programs. As Margaret Head, chief operating officer and chief nursing officer for the Vanderbilt Medical Group stated, Meaningful Use was like "slingshotting us around the moon. If I didn't have that driver, I don't think we could have driven that organizational change so rapidly."[11] Meaningful Use is providing the necessary incentives to enhance interoperability, care coordination, and patient engagement; this momentum, generated by the EHR Incentive Program, should be rewarded.

These data underscore how the investment Congress made in health IT is helping the American people as patients and as taxpayers. The incentive payments are accelerating the arc of adoption well beyond what we anticipated, and that means patients and families are beginning to reap the benefits of these reforms. We are coming to expect the presence of health IT to optimize our health and health care, just as technology has revolutionized so many other aspects of our lives.

Moving Forward

In 2009, Congress took a monumental step towards moving America's health care system into the 21st Century by passing the HITECH Act and wisely investing tax payer funds in efforts that directly benefit those same tax payers. We cannot transform an entire health information system overnight. It takes time and work. ONC and CMS are building a program that is working and a substantial stakeholder learning community that helps devise adjustments and solutions when unexpected issues arise. Patients and their families are at the threshold of accessing and sharing information about their health and care. Standards for secure and private communication between patients and their care teams, outlined in Stages 2 and 3, will soon enable patients to

[9] Centers for Medicare and Medicaid Services. "Medicare and Medicaid EHR Incentive Programs." May 7, 2013. http://www.healthit.gov/policy-researchers-implementers/hit-policy-committee-16

[10] Ibid.

[11] Robeznieks, A. Modern Healthcare. "Meaningful use can be stretch even for EHR pioneer." March 19, 2013. http://www.modernhealthcare.com/article/20130319/NEWS/303199953

engage with their providers meaningfully and participate actively in coordination, care planning, and self-care. Meaningful Use is working, and its first two stages have created the foundation for delivering care differently and supporting payment models that incentivize the kind of health care Americans need and deserve.

To answer the white paper's question, Meaningful Use should not be delayed. It is imperative that we keep Stage 2 implementation and Stage 3 rulemaking on their intended trajectory and implement the lessons learned in order to ensure that the outlay of public funds through this program results in a healthier population, better care, and more affordable health care costs.

Thank you once again for the opportunity to review and comment on the white paper. We stand ready to be a resource to you and to work with your offices and Congress at large to ensure that the Meaningful Use program holds value for all stakeholders as we move forward.

Sincerely,

American Association on Health and Disability
American Hospice Foundation
Caregiver Action Network
Caring From a Distance
Center for Democracy & Technology
Childbirth Connection
Colorado Consumer Health Initiative
Consumers Union
Healthwise
National Partnership for Women & Families
The Children's Partnership
Universal Health Care Action Network of Ohio
Lisa Fenichel, e-Health Consumer Advocate
Regina Holliday, Patient Advocate