STATEMENT OF

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ON

"IMPLEMENTATION OF THE 21ST CENTURY CURES ACT:
ACHIEVING THE PROMISE OF HEALTH INFORMATION TECHNOLOGY"

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Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for the opportunity to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to implement the health information technology (health IT) provisions of the 21st Century Cures Act.[1] CMS is committed to partnering with healthcare providers and stakeholders to harness the potential of health IT, while reducing burden on providers and ensuring high-quality care for their patients. CMS is working closely with our colleagues in the Office of the National Coordinator for Health Information Technology (ONC) and the Department of Health and Human Services Office of Inspector General (HHS-OIG) to implement this important law.

While health IT holds promise in helping clinicians communicate and in empowering patients with access to their health information, as a practicing physician, I can personally attest to the work that remains before we fully meet this promise. Electronic Health Records (EHRs) can be an important source of information and data, but the need to input data can interrupt the face-to-face time I have with my patients. CMS is hearing similar concerns from clinicians across the country. We have heard that there are too many quality programs, technology requirements, and other measures, like meaningful use measures, that get between the clinician and the patient. Clinicians have difficulty getting the data they need for reporting quality measures directly from the EHR, which should be a seamless process. Some patients struggle to access their information online. In my experience, everyone practicing medicine wants to provide the best care possible for patients, and far too often it seems the on-the-ground reality of EHRs fall short of what was envisioned. We have a long way to go before EHRs are truly interoperable, allowing clinicians, like me, to easily access health information about our patients when other providers they see use different systems.

[1] Public Law No. 114-255: https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf

CMS, by law has implemented two key programs to encourage hospitals and clinicians to adopt and effectively use certified EHRs: the Medicare and Medicaid EHR Incentive Programs (as established by the American Recovery and Reinvestment Act of 2009[2]) (for clinicians and hospitals) and the Quality Payment Program and its Advancing Care Information category (as established by the Medicare Access and CHIP Reauthorization Act of 2015[3] (MACRA)) (for clinicians). These programs are intended to encourage hospitals and clinicians to adopt and meaningfully use EHRs. While these programs have helped clinicians procure and begin to use these technologies, we are far away from the goal of interoperability, in which these systems can effectively communicate.

At CMS, we are taking a hard look at what is working and what is not working, as well as what is duplicative, and what we may be missing to help us move in the right direction and more fully realize the promise of EHRs without placing unnecessary requirements on clinicians. CMS is committed to simplifying our programs, especially for small, independent, and rural practices, while ensuring fiscal sustainability and high-quality care.

CMS is reducing burden and increasing flexibility for hospitals and clinicians through our payment policies, rulemaking, and other interactions with providers. CMS has included Requests for Information (RFIs) as part of our annual Medicare payment rulemaking process to obtain feedback on positive solutions to better achieve transparency, flexibility, program simplification, and innovation. This feedback will inform the discussion of ways to reduce burden in program requirements. Through these RFIs, CMS is starting a national conversation about improving the healthcare delivery system, how Medicare can contribute to making the delivery system less bureaucratic and complex, and how CMS can reduce burden for clinicians, providers, and patients in a way that increases quality of care and decreases costs – thereby making the healthcare system more effective, simple, and accessible while maintaining program integrity.

[2] Public Law No. 111-5: https://www.congress.gov/111/plaws/publ5/PLAW-111publ5.pdf
[3] Public Law No. 114-10: https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf

Promoting Health IT with the 21st Century Cures Act

Congress has helped to further streamline EHR adoption and use efforts with the enactment of the 21st Century Cures Act, which charges HHS with addressing some of the obstacles to realizing the promise of health IT. The implementation of this law will help to continue the adoption and use of health IT, while eliminating unnecessary requirements, and making it easier for clinicians to do what they do best: care for patients. CMS is supporting ONC's work to establish a goal for the reduction of regulatory or administrative burdens relating to the use of EHRs as well as a strategy and recommendations for meeting the goal, as required by the 21st Century Cures Act. Working closely with the ONC, CMS is looking at opportunities for improvement, particularly related to timelines, flexibility, decreased burden, and clearly defined requirements.

Electronic health information should be available and securely and efficiently shared, when and where it is needed, to support patient-centered care, enhance health care quality and efficiency, and advance research and public health. To implement the 21st Century Cures requirement for the Office of the Inspector General to investigate claims of information blocking by health information technology vendors, health information exchanges or networks, or health care providers, CMS anticipates referring any cases of information blocking it becomes aware of to the OIG. In addition, MACRA required clinicians to show that they have not knowingly and willfully limited or restricted the compatibility or interoperability of their certified EHR technology when they attest to how they used EHR technology for the purpose of the Quality Payment Program. CMS issued a rule that implemented this requirement for all clinicians in November of 2016.[4]

CMS is also examining the opportunities presented by telehealth and telemedicine technology. CMS will produce a report on the populations of Medicare beneficiaries who would most benefit from expansion of telehealth and other information that can help inform future Congressional policymaking on the future of telehealth in Medicare as requested by the 21st Century Cures Act.

[4] Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models Final Rule (CMS–5517–FC) - https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf

CMS has also begun work to establish a provider digital contact information index, another requirement of the 21st Century Cures Act, which will provide digital contact information for health professionals and facilities. This index is intended to improve the exchange of electronic health information between different providers and facilities and CMS is working with our colleagues at the ONC to ensure that this directory is useful to providers who want to contact each other and stakeholders.

Promoting Health IT though Flexibility and Alignment

In addition to implementing important provisions of the 21st Century Cures Act, CMS is using the opportunity presented by the creation of the Quality Payment Program to help reduce burden on clinicians using EHRs. The Quality Payment Program[5] includes certain aspects of three separate programs, including the Medicare EHR Incentive Program (often called "meaningful use") for physicians, into one program designed to reward clinicians for providing high quality care. The Quality Payment Program brings significant changes to how clinicians are paid within Medicare, so CMS is continuing to take implementation slowly to ensure that clinicians can easily participate and that patients are put first. CMS is using stakeholder feedback to find ways to streamline the programs to reduce clinician burden. For example, we proposed to implement a variety of participation options, including a virtual group participation option. CMS is carefully reviewing the comments we received on the Quality Payment Program proposed rule released in June 2017[6], and this Administration will continue to listen to stakeholders and take steps to support clinicians and patients by alleviating burdens and allowing them to focus on improving health outcomes.

In addition, CMS has taken the following specific steps in the last year to reduce burden and improve flexibility through our proposed and final policies related to EHRs.

[5] https://qpp.cms.gov/

[6] CY 2018 Updates to the Quality Payment Program Proposed Rule (CMS–5522–P) - https://www.gpo.gov/fdsys/pkg/FR-2017-06-30/pdf/2017-13010.pdf

- Improved Flexibility. For the EHR Incentive Program, CMS adopted for the 2018 reporting period[7], and for the Quality Payment Program, it proposed for clinicians for the 2018[8] performance period, policies that allow hospitals and clinicians to use various versions of certified EHR technology. For example, some clinicians may use the 2014 Edition while others may use the 2015 Edition, or a combination of the two. This increased flexibility encourages hospitals and clinicians to participate in the programs even if they haven't upgraded their software to the latest certified version. CMS continues to encourage clinicians and hospitals to migrate to the implementation and use of EHR technology certified to the 2015 Edition so they may take advantage of improved functionalities, but we recognize that depending on their circumstances, some hospitals or clinicians may need more time to make these updates.

- Shorter Reporting Time Frames. CMS has established the hospital EHR[9] and clinician[10] Advancing Care Information reporting periods to be a minimum of any continuous 90-day period during the calendar year for 2017 and 2018.

- Increased Alignment Between Programs. It can be challenging for hospitals and clinicians to comply with the differing requirements of multiple programs. Whenever possible, CMS has looked for ways to align the programs relevant to EHRs, including aligning the clinical quality measure requirements. As an example, under the Quality Payment Program, the Medicare clinical quality measure requirements have been aligned to eliminate any duplication in reporting. Clinicians can choose to report quality measures through their EHR system; however, if another reporting mechanism better meets their needs for reporting

[7] Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models Final Rule (CMS–5517–FC) - https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf
[8] CY 2018 Updates to the Quality Payment Program Proposed Rule (CMS–5522–P)- https://www.gpo.gov/fdsys/pkg/FR-2017-06-30/pdf/2017-13010.pdf
[9] Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates - Final Rule (CMS–1677–F) - https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf
[10] Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models Final Rule (CMS–5517–FC) - https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf

measures, such as a qualified clinical data registry, they can choose that mechanism to report.[11]

- Exception for clinicians in small practices. Additionally, in response to concerns raised by small and rural providers, CMS has also proposed a new category of hardship exceptions for small practices (15 or fewer clinicians).[12]

- Clarifying Documentation Requirements. CMS has also implemented 21st Century Cures requirements by clarifying our policy that a physician may delegate some of the EHR documentation requirements to another person as long as the physician signs and verifies the documentation.[13] This allows physicians to spend more time with patients and less time in front of a computer.

- Hardship Exceptions for Decertified EHR Technology. CMS has granted timely requests for hardship exceptions from the Medicare EHR Incentive Program for hospitals and clinicians with EHR vendor issues. As directed by the 21st Century Cures Act, this year we adopted[14] (and proposed for clinicians[15]) a specific hardship exception for hospitals and clinicians whose EHR technology becomes decertified to recognize the difficulty health care providers face when the software they have invested in becomes decertified.

- New Advancing Care Information (ACI) Exception for Clinicians Who are ASC-Based. CMS has implemented the 21st Century Cures Act provisions requiring an exception to the

[11] Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models Final Rule (CMS–5517–FC) - https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf
[12] CY 2018 Updates to the Quality Payment Program Proposed Rule (CMS–5522–P)- https://www.gpo.gov/fdsys/pkg/FR-2017-06-30/pdf/2017-13010.pdf
[13] For more information see: https://questions.cms.gov/faq.php?faqId=20477
[14] Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates - Final Rule (CMS–1677–F) - https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf
[15] CY 2018 Updates to the Quality Payment Program Proposed Rule (CMS–5522–P)- https://www.gpo.gov/fdsys/pkg/FR-2017-06-30/pdf/2017-13010.pdf

2017 and 2018 Medicare payment adjustments for clinicians who furnish 75 percent or more of their covered professional services in an ambulatory surgical center[16].

- Promote Transparency. CMS has implemented the 21st Century Cures Act provision by publicly posting data online that shows the percentage of hospitals[17] and eligible professionals[18], delineated by state, who have demonstrated meaningful use of certified EHR technology in the Medicare and Medicaid EHR Incentive Programs.

Looking Forward

As CMS looks to drive patient-centered care in all of our programs, we are listening to stakeholders and committed to using data driven insights and meaningful quality measures and technology that empowers patients and clinicians to make decisions about their healthcare. While recognizing that we have a long way to go to make health IT truly interoperable, the enactment of the 21st Century Cures Act has provided CMS with another opportunity to pursue flexibility and reduce burden on providers and patients, while helping to spur the adoption of promising technologies. We appreciate the Committee's ongoing interest and commitment to this important work, and look forward to continuing to work with you.

[16] Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates - Final Rule (CMS–1677–F) - https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf

[17] https://dashboard.healthit.gov/quickstats/pages/FIG-Hospitals-EHR-Incentive-Programs.php

[18] https://dashboard.healthit.gov/quickstats/pages/FIG-Health-Care-Professionals-EHR-Incentive-Programs.php