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Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for the opportunity to discuss our work at the Centers for Medicare & Medicaid Services (CMS) related to health information technology (health IT). CMS is committed to working with providers and stakeholders to harness the potential of health IT to improve the quality and reduce the cost of care—and, more broadly, transform our Nation's health care delivery system.

As a result of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, adoption of electronic health records continues to increase among physicians, hospitals, and others serving Medicare and Medicaid beneficiaries. Higher EHR adoption has helped care providers evaluate patients' medical status, coordinate care, eliminate redundant procedures and provide high-quality care. The proportion of U.S. physicians using Electronic Health Records (EHRs) increased from 18 percent to 78 percent between 2001 and 2013, and 94 percent of hospitals now report use of certified EHRs. EHRs also will help speed the adoption of key delivery-system reforms by making it easier for hospitals and doctors to better coordinate care and achieve improvements in quality.

Earlier this year, Health and Human Services Secretary Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. Such incentives will help achieve the critical goal of improving care delivery and access to information. Encouraging the use of health IT is an important component of HHS efforts to transform the delivery system. It supports the health information exchange needed to improve communication and care coordination, promote patient safety, enhance clinical decision making, track patient outcomes and support payment for care quality. Health IT helps provide the information needed to clinicians and patients at the point-of-care.

On April 16, 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA),[1] which supports the Secretary's goals by requiring the implementation of new payment systems for physicians and other practitioners in Medicare by 2019: the Merit-Based Incentive Payment System and Alternative Payment Models,. Together, these important steps to transform the way Medicare pays practitioners will promote a long-term business case for effective health IT adoption and, in turn, lead to better care and improved outcomes.

Health IT is an important catalyst for improving care delivery, enabling providers to prepare for and be successful under new alternative payment models. Under new payment models, it is increasingly critical for providers to communicate effectively across care settings, quickly and easily share health information, reduce duplicative and unnecessary care, successfully manage high-risk populations and engage patients in their care by communicating and sharing test results electronically. Effective use of health IT can help providers achieve those aims: helping a patient transition safely from the hospital to the home by enabling inpatient and outpatient providers to quickly and easily share key information; helping patients communicate with providers through secure, electronic messaging; and helping providers identify and communicate with patients who are in need follow-up care to address their chronic condition(s). Additionally, many providers now are using clinical and patient-submitted data from health IT systems to track and improve population health.

While the use of health IT can promote higher-quality care delivery, we also recognize that providers face costs when adopting and implementing new EHRs and other health IT systems, such as the up-front cost to purchase new technology and the indirect cost of the provider's time to incorporate that new technology into practice workflow. By aligning CMS programs and providing flexibility, we aim to ensure that providers focus their resources on delivering high-quality care for our beneficiaries.

[1] PL 114-10 https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf

CMS is focused on efforts to simplify our program requirements to lower administrative requirements and create a clear link between program participation and better outcomes. These include providing provider flexibility in achieving meaningful use of certified EHR technology and aligning quality measures across payment programs. At the same time, CMS is supporting the ongoing efforts of the Office of the National Coordinator for Health IT (ONC) to make electronic health information more readily transferable and to promote more user-centric EHR systems. We believe this work will support providers as they adopt and use health IT and work to deliver better care for Medicare and Medicaid beneficiaries.

Encouraging EHR Adoption

Since the passage of the American Recovery and Reinvestment Act of 2009 ("Recovery Act"), CMS has been hard at work implementing financial incentives and technical assistance to encourage the widespread use of certified EHR technology to improve quality, safety and efficiency; reduce health disparities; engage patients and families; improve care coordination; improve population and public health; and maintain the privacy and security of patient health information.

The Recovery Act established the Medicare and Medicaid EHR Incentive Programs, which provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. To receive an EHR incentive payment under Medicare, providers must demonstrate that they are "meaningfully using" their certified EHR technology by meeting thresholds for a number of objectives and reporting clinical quality measures.

States verify eligibility for the Medicaid EHR Incentive Program. Several additional types of health care providers are eligible for Medicaid EHR incentive payments, including nurse practitioners, certified nurse-midwives, dentists, and physician assistants who furnish services at a physician assistant-led Federally Qualified Health Center or Rural Health Clinic. There also are patient-volume thresholds that providers must meet to be eligible for EHR incentive payments under Medicaid. Children's hospitals, however, are eligible for Medicaid incentive payments regardless of Medicaid patient volume. In their first year in the Medicaid EHR Incentive

Program, Medicaid providers also have the option to receive incentive payments based on whether they adopt, implement or upgrade a certified EHR technology.

The Medicare and Medicaid EHR Incentive Programs have progressed in stages, moving from basic data capture to advanced functionality of EHRs, including interoperability, patient engagement, clinical decision support, and quality measurement and then to increased health information exchange, interoperability and improved patient outcomes. This last phase, referred to as "Stage 3," would make changes that are responsive to stakeholders asking for more time, flexibility and simplicity in the program.[2]

Participation in the Medicare and Medicaid EHR Incentive Programs remains strong. As of July 2015, more than 474,000 health care providers received payment for participating in either the Medicare or Medicaid Incentive Program. More than $20.9 billion in Medicare EHR Incentive Program payments were made between May 2011 and July 2015. In addition, more than $9.98 billion in Medicaid EHR Incentive Program payments were made between January 2011 (when the first set of states launched their programs) and July 2015.[3] As of July 2015, over 300,000 unique providers had received Medicare EHR Incentive Program payments under Stage 1 and over 50,000 providers had received payments under Stage 2.[4]

Reducing Administrative Requirements and Increasing Flexibility

CMS is taking several steps to streamline Medicare and Medicaid EHR Incentive Program requirements and provide flexibility based on lessons learned from the initial years of operating the programs. For example, in March we proposed that Stage 3 will be optional in 2017,[5] giving program participants and industry more time to implement changes, update workflows and adopt new technology.

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[2] Electronic Health Record Incentive Program – Stage 3 Notice of Proposed Rulemaking https://www.federalregister.gov/articles/2015/03/30/2015-06685/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3

[3] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/July2015_PaymentsbyStatebyProgramandProvider.pdf

[4] Ibid

[5] Electronic Health Record Incentive Program – Stage 3 Notice of Proposed Rulemaking https://www.federalregister.gov/articles/2015/03/30/2015-06685/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3

CMS also aims to streamline and reduce overall reporting requirements. We analyzed the objectives and measures of the program to determine where measures are redundant, duplicative or have "topped out."[6] . For Stage 3 specifically, based on this analysis, we proposed an aligned set of eight objectives and measures for eligible professionals and hospitals, down from 20[7] in Stage 2.[8] If finalized, we believe these changes will focus provider efforts on objectives that pertain to the advanced use of EHRs, such as using data to drive improvements in care coordination, care management and population health outcomes.

Providers have indicated to CMS that they need flexibility in implementing the objectives and measures of meaningful use in diverse clinical settings. As a result, we proposed to give eligible professionals measure options within several objectives to allow providers to report on measures most applicable to their practice.[9] In addition, CMS proposed to focus objectives and measures on interoperability requirements, such as allowing the use of Application Program Interfaces and focusing on electronic exchange of health information between providers. In Stage 3, more than 60 percent of the proposed Meaningful Use measures require interoperability, up from 33 percent in Stage 2.

Finally, we are aligning clinical quality measure reporting requirements across payment programs to reduce reporting requirements and focus provider efforts on high-impact outcomes-based measures. Today, eligible professionals in the Medicare EHR Incentive Program that report quality measures to CMS electronically can receive credit in both the EHR Incentive

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[6] "Topped out" is the term used to describe measures that have achieved widespread adoption at a high rate of performance and no longer represent a basis upon which provider performance may be differentiated. It is commonly used to justify removal of specific clinical quality measures from public and private sector quality reporting programs.

[7] Eligible Providers must achieve 20 Meaningful Use Objectives in Stage 2; Eligible Hospitals must achieve 19, see Stage 2 final rule here: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

[8] Electronic Health Record Incentive Program – Stage 3 Notice of Proposed Rulemaking https://www.federalregister.gov/articles/2015/03/30/2015-06685/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3

[9] For example, providers must report the numerator and denominators for all three measures within the Health Information Exchange objective. However, providers are only required to achieve the thresholds for two measures to meet the objective. See Electronic Health Record Incentive Program – Stage 3 Notice of Proposed Rulemaking https://www.federalregister.gov/articles/2015/03/30/2015-06685/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3

Program and the Physician Quality Reporting System.[10] These results also will be used in calculating eligible professionals' performance under the physician value modifier and future value based purchasing initiatives. The CMS goal is to allow providers to report once for all applicable quality programs. We also are working to align CMS quality measures with those used by the private sector, concentrating provider efforts and lowering the reporting burden for those providers that submit data to both public and private payers. While we are removing "topped-out" and outdated measures, we are simultaneously working to fill measure gaps by developing measures for important health conditions and provider types where sufficient measures have yet to be created. Over time, these measures will be added to our quality programs, making them more relevant to certain specialties and better reflective of the latest evidence base.

Health IT and Delivery System Reform Initiatives

CMS is working hard to implement MACRA, which will promote the adoption of new payment and service delivery models. The law creates a value-based physician payment system (Merit-Based Incentive Payment Systems or MIPS), and the adoption and meaningful use of health IT will be one of the categories for determining how Medicare provider performance is assessed – and rewarded – under MIPS. MACRA also encourages participation in alternative payment models by requiring eligible professionals participating in such models to use certified EHR technology.

Adopting health IT enables capabilities – like efficient communication across care settings, safe prescribing and managing overall population health – that are central to improving care and lowering costs. In addition to implementing MACRA, CMS is supporting the business case for EHR adoption through targeted initiatives that encourage health care providers to deliver high-quality, coordinated care at lower costs. These reforms enable us to pay based on value while promoting patient safety and better care coordination across the health care delivery system.

[10] Electronic Health Record Incentive Programs Stage 2 Final Rules: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

CMS initiatives include Accountable Care Organizations (ACOs)—groups of doctors and other health care providers that have agreed to work together to treat individual patients and better coordinate their care across care settings. They have the opportunity to share in savings generated from lowering the growth in health care costs while improving quality of care, including a measure that promotes use of EHR technology. Medicare ACOs have already demonstrated significant cost savings and improvements in quality. In 2014, 20 Pioneer and 333 Shared Savings Program ACOs generated more than $411 million in savings. Pioneer ACOs also showed improvements in 28 of 33 quality measures and experienced average improvements of 3.6 percent across all quality measures. Shared Savings Program ACOs that reported quality measures in 2013 and 2014 improved on 27 of 33 quality measures.

Another example is the Comprehensive Primary Care Initiative (CPC),[11] which is a multi-payer partnership between Medicare, Medicaid, private health care payers and primary care practices in four states[12] and three regions.[13] CMS requires all participants in CPC to use ONC Certified EHR Technology. A few of the ways the practices use such certified technology include: (1) reporting their practice results for all electronic clinical quality measures; (2) risk-stratifying their patient populations to focus on patients likely to benefit from active intensive care management; (3) ensuring patients can reach a member of their care team who has real-time access to their EHRs 24 hours a day; and (4) achieving meaningful use. Results from the first year suggest CPC, on average across seven regions, has generated nearly enough savings in Medicare health expenditures to offset care management fees paid by CMS, with hospital admissions decreasing by two percent across all sites and emergency department visits decreasing by three percent.

Finally, CMS is testing bundled-payment models,[14] which link payments for multiple services beneficiaries receive during a single episode of care, encouraging doctors, hospitals and other health care providers to work together on delivering coordinated care for patients. CMS recently

[11] http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/
[12] Arkansas, Colorado, New Jersey and Oregon.
[13] New York's Capital District and Hudson Valley, Ohio and Kentucky's Cincinnati-Dayton region, and Oklahoma's Greater Tulsa region.
[14] http://innovation.cms.gov/initiatives/bundled-payments/

proposed the Comprehensive Care for Joint Replacement initiative that would build upon other bundled-payment models already being tested by the Centers for Medicare and Medicaid Innovation. Providers and suppliers in the proposed joint replacement initiative would be paid under the existing payment systems in the Medicare program for services provided during episodes of care for hip and knee replacements. Following the end of a model's performance year, actual episode spending for beneficiaries who receive certain joint-replacement surgeries in a participant hospital would be compared to the Medicare episode price. Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or, beginning in the second year of the model, may need to repay Medicare for a portion of the episode spending. This proposed initiative, like other bundled-payment models, incentivizes the type of close collaboration among inpatient and outpatient providers and suppliers that is made easier with the effective use of health IT.

Although designed for different providers and care settings, all of these initiatives promote well-coordinated, high quality care and build the business case to adopt health IT systems that help providers manage population health and share information across care settings.

Conclusion

CMS will continue to support the adoption and effective implementation of health IT that supports better care and lower costs for Medicare and Medicaid beneficiaries. While health IT alone does not make care better, it is an essential ingredient to improvement of care and supporting providers as they transition from volume-based to value-based payment models. Health IT moves us away from illegible notes and prescriptions, reams of paper charts, x-rays that cannot be found and lost faxed lab results towards a health system where relevant information is available for providers at the point of care and for patients when they need it at home or at the pharmacy. As a practicing physician, I have experienced the power of health IT to improve care and patient safety, and I also realize that we need to continue to improve the programs and products so they support clinicians and patients in achieving better outcomes.

CMS's primary goal is to ensure that beneficiaries and providers can realize all of the benefits of EHR systems without unnecessary costs. Providers should be confident that their time and

resources will be spent caring for patients rather than unnecessary or duplicative administrative requirements. CMS will continue our work with ONC to improve interoperability, make health IT more user-friendly, and streamline program requirements as we work to transform the health care delivery system and promote high-quality care.