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Thank you, Chairman Burgess, Ranking Member Green and members of the subcommittee. It is an honor to be here today to testify on behalf of the College of Healthcare Information Management Executives, or CHIME, concerning the Meaningful Use Program and to offer our support for H.R. 3120, a bill to reduce the volume of future electronic health record-related significant hardship requests.

CHIME is an executive organization serving nearly 2,400 Chief Information Officers (CIOs) and other senior health information technology leaders at hospitals, health systems and clinics across the nation. CHIME members are responsible for the selection and implementation of the clinical and business technology systems that are facilitating healthcare transformation.

In addition to serving as chairman-elect of the CHIME board of trustees, I am the Chief Information Officer of Kaleida Health. Kaleida Health is the largest health care provider and largest private employer (10,000 employees) in Western New York State. More than one million patient visits are recorded annually at the Buffalo General Medical Center, DeGraff Memorial Hospital, Gates Vascular Institute, Millard Fillmore Suburban Hospital, Women & Children's Hospital of Buffalo, plus the health system's 82 clinics and health care centers.

Kaleida Health operates HighPointe on Michigan and the DeGraff Memorial Hospital skilled nursing facility, plus the nation's oldest – and original - Visiting Nursing Association. Kaleida Health also operates a major laboratory division and two surgery centers. The organization is also affiliated with Great Lakes Health, the entity integrating Kaleida Health, Erie County Medical Center (ECMC) Corporation and the University at Buffalo. Kaleida Health's economic impact on Western New York exceeds $2.7 billion annually.

CHIME members represent some of the earliest and most prolific adopters of electronic health records (EHRs) and other health IT resources for clinicians and patients. Since enactment of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), which established the Medicare and Medicaid Electronic Health Record Incentive Programs also known as the Meaningful Use program, the healthcare industry has made a significant shift in the way technology is used to treat and engage with patients. The prolific adoption of EHRs and other health IT resources by clinicians and patients has and will continue to pay dividends in the nation's efforts to improve patient outcomes and reduce costs. We also believe that providers' use of these systems will continue to evolve as technology matures and as providers become more skilled with its use.

Patients and providers have already benefited from the nation's investment into EHRs, as organizations have begun to leverage the data collected in the EHRs to conduct activities to improve population health. This would not have been possible without the investments made through the HITECH Act funds. As an example, in another health system where I previously served as a CIO, we were able to track hospital readmissions that were related to asthma and correlate asthma-related hospital readmissions to specific neighborhoods and specific properties. With that data, we worked with local officials to coordinate discussions with landlords to improve conditions of specific properties within those neighborhoods. These kinds of population health activities would not be possible if we did not have EHRs and access to data digitally.

We have just begun to see the potential of EHRs and other digital health tools to transform care delivery. Given the rapid acceleration of the program since inception, we have not had the necessary time to optimize and realize anywhere near the full potential of these tools. We have not been able to focus on enhancing workflows or usability, or explore additional functionalities beyond what is required for the Meaningful Use program. Healthcare delivery has undoubtedly improved with the introduction of health IT tools, but it is far from ideal.

As we stand now, more than eight years after passage of HITECH, there exists an opportunity to make policy decisions apart from the arbitrary deadlines and measures of the EHR Incentive Program. We are at an inflection point where our gains can be used to pivot towards the long-term goal of building and supporting a national digital health ecosystem that is interoperable and which best supports patient outcomes.

Meaningful Use in Numbers
As of May 2017, of the 637,700[1] eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) were actively registered in the Medicare and Medicaid EHR Incentive Programs, more than 525,700[2] healthcare providers had received payment for participating in the Meaningful Use program. More than $24.6 billion[3] in Medicare EHR Incentive Program payments have been made between May 2011 and May 2017. In addition, more than $11.9 billion[4] in Medicaid EHR Incentive Program payments have been made between January 2011 (when the first set of states launched their programs) and May 2017.

Understandably, the requirements providers are held to should also evolve; however, they must do so in a manner that leaves adequate time for providers to absorb the pace of change and facilitates better patient care. According to the Centers for Medicare & Medicaid Services (CMS), an estimated 256,000[5] or 43 percent of Medicare providers, were subject to negative payment adjustments under the Meaningful Use program in the 2015, while 56,000 hardship exemptions were granted for Medicare physicians. In 2016, 209,000[6] Medicare physicians received a payment adjustment with 31,580 hardship exemptions granted. In 2017, 171,000[7] physicians received a payment adjustment.

In 2015, about 200 hospitals out of the 4,444 hospitals that attested to the Meaningful Use program were subject to a negative market basket adjustment for failing to meet Meaningful Use requirements and hardship exemption data was not publicly released. In 2016, 206 hospitals were subject to a payment adjustment and 62 hospitals were granted a hardship exemption. In 2017,

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[1] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html

[2] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html

[3] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html

[4] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html

[5] https://www.healthit.gov/facas/sites/faca/files/Joint_EHR_Incentive_Program_FINAL_2015-02-10_0.pdf

[6] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_PaymentAdjustmentFactSheet.pdf

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

CMS stated that about two percent[8] of hospitals received a payment adjustment in 2017 and hardship exemption data has yet to be released for 2017.

Thus, while EHR adoption has surpassed expectations and the vast majority of providers leverage a certified EHR to deliver care, many providers are still unable to comply with the requirements set forth by CMS in the Meaningful Use program and have either been subject to financial penalties or have needed hardship exemptions.

The Escalated, Staged Approach to Meaningful Use

The escalated, staged approach adopted by CMS since the program's inception has failed to acknowledge the timelines necessary to execute the requirements they adopt through rulemaking, which go far beyond what was included in the HITECH statue. CHIME has repeatedly urged CMS to recognize the time needed for development by the EHR vendors, deployment to all eligible EPs and EHs and actual implementation by providers and health systems.

We continue to impart the importance of allowing both vendors and providers adequate time to both develop and deploy solutions. We reiterate our suggested timelines as affording adequate time to develop and test for a major upgrade, which could take months if not more than a year for an update as significant as a new edition of certified technology. This does not include the time it takes for a provider to deploy the solution. Providers, depending on their size, need anywhere from 8-18 months to install software prior to the start of a reporting period to make the necessary workflow and training changes and to do so in a manner that best supports patient safety.

This is especially timely as we approach 2018, which marks the first year that hospitals are expected to comply with the Stage 3 measures and objectives; it is option for physicians in the Quality Payment Program (QPP). To comply with Stage 3, hospitals will need 2015 Certified Electronic Health Record Technology (CEHRT.) Unfortunately, 2015 CEHRT is not widely available to our members today. According to a small survey we conducted in April 2017, 81 percent of members surveyed have not yet received their 2015 CEHRT. More than 70 percent say they do expect to receive their updated software by July 1, 2017. Further, more than 70 percent say they will not be ready for the January 1, 2018 compliance date. CHIME members are very apprehensive about the looming requirement that mandates use of 2015 Edition CEHRT starting January 1, 2018. This issue, combined with the requirement that providers begin meeting Meaningful Use Stage 3, places many hospitals at significant risk of a penalty.

Finally, the current cadence of change is adding to development and deployment times, as well as the total operational costs of every healthcare organization. The program has been plagued by timeline changes, clarifications or amendments to measure specifications and threshold adjustments. Although the provider and vendor communities often welcome these decisions, they typically occur at the very last minute. For example, in 2015 CMS changed the reporting period for Meaningful Use program participants to 90 days on October 6, 2015, three days after the start of the final 90-day reporting period possible during that performance year.

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

Reducing Reliance on Hardship Exemptions

To fully harness the power of health IT across the continuum, additional flexibility must be woven into both the construct and administration of the Meaningful Use program. Without key refinements to the program, efforts to improve nationwide interoperability and information exchange will not progress as quickly as patients deserve. Thus, we offer our enthusiastic support for H.R. 3120. We share concerns about the trajectory of the program and appreciate your efforts to provide greater stability for our members as they navigate transitions to new payment models and the drive toward high-value care.

As hospitals and providers continue to struggle with the meeting the timelines and requirements of the Meaningful Use program, there will become an increased reliance on hardship exemptions. For the 2017 program year, EPs transitioning to Advancing Care Information (ACI) performance category under the Merit-based Incentive Payment System (MIPS) in the Medicare Access and CHIP Reauthorization Act (MACRA) programs who have never participated in the Meaningful Use program can file for a hardship exemption. In 2015, CMS clarified that hospitals or physicians that are transitioning to different EHR platforms may file for a hardship exemption under the "Extreme and/or Uncontrollable Circumstances." This clarification acknowledges that the process of "switching vendors" is immensely costly and may take years. While hardship exemptions are welcome to avoid payment adjustments, they also mean participants were not able to participate successfully in the program.

However, our members would prefer to participate in the program, whether that be through more reasonable reporting requirements or timelines, rather than file for a hardship exemption. Maintaining momentum toward a digital transformation is vital. CIOs will do anything possible to see that their institutions continue to embrace technology and embody the goals of the HITECH Act.

The Future of Meaningful Use

We commend the approach taken in H.R. 3120. Rather than propose the elimination of the Meaningful Use program or insist that requirements remain stagnant in perpetuity, it leaves it to the discretion of the Secretary to modify the requirements over time as deemed necessary in conjunction with the industry. Meeting the requirements established in regulations that often consist of 1,000 or more pages places unreasonable demands on limited resources and finances. The ability to shift away from that continual churn would be a welcome development for the provider community.

The healthcare landscape has changed dramatically since the passage of HITECH, as have CIO priorities. The 21st Century Cures Act placed a necessary spotlight on the need for nationwide interoperability, for improvements to the cybersecurity of EHRs and the importance of improving the usability, for patients and clinicians alike, of EHRs. The Meaningful Use program and the nation's patients should benefit from the policies enacted in 21st Century Cures Act and not be forced to comply with arbitrary deadlines to advance in the program, especially as the industry evolves and matures.

The HITECH Act facilitated near ubiquitous adoption of EHRs among clinicians and hospitals. More time at the current stage will not stymie the progress that has been made to date. In fact, providers are eager to optimize the use of this valuable technology to best meet their needs and the needs of their patients. At Kaleida, we are in a Comprehensive Primary Care Plus (CPC+) region, in addition to participating in accountable care organizations (ACOs) and other clinically integrated networks. As we strive to both enhance care coordination and increase system efficiencies, health information technology, led by the EHR, will be critical. Thus, the Meaningful Use program is not the sole driver of health IT adoption and use.

Further, health system resources are needed to meet the evolving information technology needs of their clinicians and patients. For example, one of the unintended consequences of digitizing the nation's healthcare delivery system has been the explosion of cybersecurity threats.

CHIME's CIO members now identify cybersecurity as their top priority, replacing Meaningful Use and accurate patient identification. CIOs and their provider colleagues are balancing the complex Meaningful Use requirements, including the forthcoming mandate to implement Application Programming Interfaces (APIs), that are neither standardized or secure[9]. The recent Health Care Industry Cybersecurity Task Force report published by the U.S. Department of Health & Human Services (HHS) and submitted to Congress concludes, "Regulatory mandates that will force all EHR vendors to have a shared, publicly-available application interface could expose EHRs to additional attack vectors." Some of our members are also concerned that immature APIs could create new risks for the theft of patient medical records and other protected data. Yet providers are expediting adoption of APIs, not because they have been widely tested and utilized within the industry, but because they are mandated under both Meaningful Use and the Advancing Care Information performance category under MIPS. However, if the Meaningful Use program did not escalate as it does today, there may be time to test on a small scale the use of APIs, which could offer some valuable lessons learned prior to immediately moving forward with a full-scale national deployment. Providers are eager to deploy solutions that will allow for active engagement with patients and caregivers. However, they want to make sure this is done in a manner that will not jeopardize patient data and leave their networks vulnerable to external threats.

The Path Ahead

As the nation shifts away from fee-for-service care delivery and increased focus on outcomes, it will be imperative that the Meaningful Use program match the industry's trajectory and goals. Moving away from the "check-the-box" and "one-size-fits-all" approach will be imperative to ensure that providers and health systems are best able to meet the needs of their local communities, to focus on the conditions and unique needs of their patients, rather than measures that have been dictated by the federal government.

Health information exchange is in its infancy, and interoperability has not and will not be a direct result of the Meaningful Use program. It is imperative that the federal government, along with

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[9] https://www.phe.gov/Preparedness/planning/CyberTF/Documents/report2017.pdf

the private sector, as directed in the 21ˢᵗ Century Cures Act, prioritize policies like the adoption of robust healthcare data standards and the ability to link patients to their records across all care settings. There is no question that the federal government must have a role in facilitating interoperability, but, it should not be implied, nor assumed, that it is going to occur with the measures proposed for the Meaningful Use program.

The Meaningful Use program expedited the digital transformation in healthcare, but we have a long journey ahead. Ensuring that policies, including what is proposed by H.R. 3120, are able to deliver commonsense flexibilities to the nation's healthcare systems and providers will be invaluable in once again making the Meaningful Use program "meaningful."

The Committee's interest in this topic is timely, and efforts to usher in an era of digital care are a must. On behalf of CHIME and my colleague healthcare CIOs, I sincerely thank the Committee for allowing me to speak on opportunities to improve the Meaningful Use program and to reiterate our support for H.R. 3120. I look forward to answering your questions.