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June 3, 2016

Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: RFI Regarding Assessing Interoperability for MACRA
330 C Street, SW
Washington, DC 20201

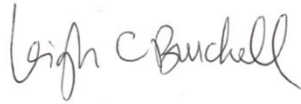
Representing more than 30 companies that develop and support electronic health records (EHRs), we are pleased to submit our comments on the Office of the National Coordinator for Health Information Technology's (ONC's) request for information (RFI) regarding assessing interoperability for Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Our comments reflect the collective experiences of software engineers employed by our member companies who have been working with hospitals and ambulatory care organizations across the US for decades to integrate disparate systems to accurately and securely share patient information, both within those care delivery organizations and with other healthcare providers. Responses to RFI questions are attached to this letter, and our key points are summarized here.

First of all, the EHR Association strongly recommends that ONC use meaningful use metrics as a readily available short term data source for assessing interoperability. This is appropriate because the definition of interoperability to be measured should be grounded by the MACRA definition, which is based on the Stage 2 criteria focusing on care coordination. Meaningful use provides adequate data among participating healthcare organizations to provide a valid assessment of operational interoperability. We do not believe that providers should be required to collect new, additional data to support this effort.

This is particularly important if ONC expects to establish and validate these metrics by the end of 2018. Variability in other types of interoperability will make it difficult to assess levels of interoperability unless we take advantage of the measures that are already in place, while exploring targeted surveys to understand the actual use and value of data received.

The Association looks forward to working with ONC and other stakeholders to advance our understanding of the levels and types of interoperability working today, as we collaborate to accelerate the exchange of patient information across communities and eventually the nation.

Sincerely,

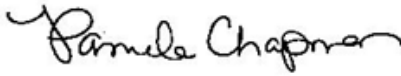


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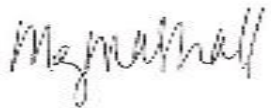
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About the EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of over 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families.

The EHR Association is a partner of HIMSS. For more information, visit www.ehrassociation.org.

Response to ONC RFI Questions re How to Measure Interoperability

1. *Should the focus of measurement be limited to “meaningful EHR users,” as defined in this section (e.g., eligible professionals, eligible hospitals, and CAHs that attest to meaningful use of certified EHR technology under CMS’ Medicare and Medicaid EHR Incentive Programs), and their exchange partners? Alternatively, should the populations and measures be consistent with how ONC plans to measure interoperability for the assessing progress related to the Interoperability Roadmap? For example, consumers, behavioral health, and long-term care providers are included in the Interoperability Roadmap’s plans to measure progress; however, these priority populations for measurement are not specified by section 106(b)(1)(B)(i) of the MACRA.*

The EHR Association recommends focusing meaningful use metrics to evaluate progress toward our shared interoperability objectives in the short timeframe between now and 2018. Meaningful use metrics have the advantage of having already been standardized through the meaningful use program and having been widely captured and already reported to CMS. In addition to the meaningful use metrics listed by ONC, we suggest considering:

- Sending e-prescriptions
- Incoming lab results
- Incoming imaging results
- Sending to immunization registries
- Sending reportable labs to public health
- Sending syndromic surveillance data to public health

Any volume measures considered should not require any additional data collection from providers. Metrics to understand the value of interoperability require careful thought and research. In particular, the industry will want to work on metrics of the value of interoperability that do not increase burden on providers.

We recognize that, of course, there are many domains of interoperability outside the scope of meaningful use requirements, and that many of these might be useful areas for ONC to look at in the longer term, as mentioned in the ONC Roadmap. In the longer term, we urge ongoing work on while considering how to measure the value of interoperability, such as, the use of the data upon receipt or the impact on cost.

2. *How should eligible professionals under the Merit-Based Incentive Payment System (MIPS) and eligible professionals who participate in the alternative payment models (APMs) be addressed? Section 1848(q) of the Social Security Act, as added by section 101(c) of the MACRA, requires the establishment of a Merit-Based Incentive Payment System for MIPS eligible professionals (MIPS eligible professionals).*

For MIPS, we recommend using the CMS’s advancing care information (ACI) performance category and meaningful use continuity as short term measures.

APMs will vary in how they promote interoperability based on the outcomes on which they focus. There could be challenges in measurement of interoperability in APMs on a 2018 timeframe given these variances.

3. *ONC seeks to measure various aspects of interoperability (electronically sending, receiving, finding and integrating data from outside sources, and subsequent use of information electronically received from outside sources). Do these aspects of interoperability adequately address both the exchange and use components of section 106(b)(1) of the MACRA?*

Electronically sending, receiving, finding, and integrating data from outside sources, and subsequent use of information electronically received cover many use cases of interoperability. The EHRA association suggests as indicated in the prior question to focus on existing meaningful use metrics for the short-term 2018 requirements, while exploring other measurements for the future based on targeted surveys and samples to understand long-term impact.

4. *Should the focus of measurement be limited to use of certified EHR technology? Alternatively, should we consider measurement of exchange and use outside of certified EHR technology?*

Certified electronic health record technology (CEHRT) can provide useful information about interoperability, such as reporting meaningful use metrics as defined in certification. However, some data that may support measurement of interoperability is not included in meaningful use and may not always be available in CEHRT. We encourage that other data sources also be considered and included where pertinent.

5. *Do the survey-based measures described in this section, which focus on measurement from a health care provider perspective (as opposed to transaction-based approach) adequately address the two components of interoperability (exchange and use) as described in section 106(b)(1) of the MACRA?*

We believe that the suggested measures provide insight into the exchange metrics, but fall short of understanding the use of the data received and value it created to the provider and patient. Therefore, when focusing on attainable measures for 2018 that demonstrate widespread interoperability the first measure would be adequate and appropriate, while longer term these need to be complemented with further focused research and surveys to address the intent behind the second and third measure.

6. *Could office-based physicians serve as adequate proxies for eligible professionals who are “meaningful EHR users” under the Medicare and Medicaid EHR Incentive Programs (e.g. physician assistants practicing in a rural health clinic or federally qualified health center led by the physician assistant)?*

In the short term, office-based physicians are adequate proxies for eligible professionals. We urge that longer term research consider the larger group of the care team.

7. *Do national surveys provide the necessary information to determine why electronic health information may not be widely exchanged? Are there other recommended methods that ONC could use to obtain this information?*

We think that currently available meaningful use metrics are sufficient to consider in a short term assessment of interoperability status. We also encourage evaluation of other sources of information as they become available to provide a deeper understanding of the contribution of interoperability to the targeted outcomes.

8. *Given some of the limitations described above, do these potential measures adequately address the “exchange” component of interoperability required by section 106(b)(1) of the MACRA?*

The measures proposed on page 15 of ONC’s RFI seem like a good starting point.

9. *Do the reconciliation-related measures serve as adequate proxies to assess the subsequent use of exchanged information? What alternative, national-level measures (e.g., clinical quality measures) should ONC consider for assessing this specific aspect of interoperability?*

It is reasonable to look at these as available data sources today. We note that that volume of reconciliations is not always a direct indicator of value/use of reconciliation, which would need further study. As future quality measures are developed to measure interoperability outcomes, the EHRA looks forward to providing input in that process.

10. *Can state Medicaid agencies share health care provider-level data with CMS similar to how Medicare currently collects and reports on these data in order to report on progress toward widespread health information exchange and use? If not, what are the barriers to doing so? What are some alternatives?*

The EHR Association defers to other stakeholders on this question. Consistency for comparable measures will be important for a valid measurement.

11. *These proposed measures evaluate interoperability by examining the exchange and subsequent use of that information across encounters or transitions of care rather than across health care providers. Would it also be valuable to develop measures to evaluate progress related to interoperability across health care providers, even if this data source may only available for eligible professionals under the Medicare EHR Incentive Program?*

We are not clear on what is meant with this question. We suggest that the measures available under the Medicare EHR Incentive Program for eligible professionals and eligible hospitals provide a starting point to address exchange across health care providers. Alternatively, is ONC suggesting the need to normalize measures by number of participants?

12. *Should ONC select measures from a single data source for consistency, or should ONC leverage a variety of data sources? If the latter, would a combination of measures from CMS EHR Incentive Programs and national survey data of hospitals and physicians be appropriate?*

A meaningful measure of interoperability will require a variety of sources, and a method to normalize those data sources. For example, when considering e-prescribing as a metric, meaningful use data could be compared to or supplemented by data from e-prescribing networks.

13. *What, if any, other measures should ONC consider that are based upon the data sources that have been described in this RFI?*

The measures proposed on page 15 of the RFI are reasonable, as are ePrescribing, labs, imaging results, and public health reporting as indicated in our response to the first question.

14. *Are there Medicare claims based measures that have the potential to add unique information that is not available from the combination of the CMS EHR Incentive Programs data and survey data?*

The Association is unaware of claims-based measures that might add unique information on data exchange, but this could be an interesting area for future research to correlate the impact of interoperability on factors such as cost.

15. *If ONC seeks to limit the number of measures selected, which are the highest priority measures to include?*

We reiterate earlier points regarding short and long term goals. In the near term, data available through the meaningful use program should be the focus for measuring the current level of interoperability among participating organizations and individuals. Integrating and incorporating data from outside sources is more difficult to measure and should be further out on the proposed timeline, including sample surveys that further explore the value that the data exchanged brings to the providers.

16. *What, if any, other national-level data sources should ONC consider? Do technology developers, HISPs, HIOs and other entities that enable exchange have suggestions for national-level data sources that can be leveraged to evaluate interoperability for purposes of section 106(b)(1) of the MACRA (keeping in mind the December 31, 2018 deadline) or for interoperability measurement more broadly?*

Health information exchanges and e-prescribing networks might be useful sources of data.

17. *How should ONC define “widespread” in quantifiable terms across these measures? Would this be a simple majority, over 50%, or should the threshold be set higher across these measures to be considered “widespread”?*

We suggest that “widespread” will need to be determined based on past metrics on these measures and contextual knowledge of what might be expected. Denominator(s) and metrics can be refined over time as we gain experience.