



## Electronic Health Record Association Interoperability Recommendations for States October 2016

Representing more than 30 companies that develop and support electronic health records (EHRs) in hospitals and ambulatory care environments across the US, the Electronic Health Record Association (EHRA) offers the following information on the progress being made nationwide in achieving more widespread interoperability among healthcare provider organizations. We have stated in a number of forums – responses to proposed regulations, Congressional briefings, and in a variety of stakeholder meetings and conversations – that we do not believe that additional state or federal legislation is necessary or desirable as a means to achieve broad-based interoperability, especially given that many legislative proposals target areas where government mandates and other intervention would either be duplicative or even disruptive of current private sector efforts. Some examples that support our position:

- **Interoperable data exchange is occurring now.** [The Office of the National Coordinator for Health IT \(ONC\)](#) announced at its 2016 annual meeting in May 2016 that 85 percent of hospitals sent data outside their organizations in 2015, up from 78 percent the previous year. National cross-provider, cross-vendor initiatives, such as [Direct Connect](#), [Carequality](#), and [CommonWell](#), are gaining traction and overcoming many of the limitations of geographically-based health information exchange. For example, the [eHealth Exchange](#), a rapidly growing network of exchange partners who securely share clinical information using a standardized approach, serves more than 100 million patients amongst their members in all 50 states and includes in its membership four federal agencies (DoD, VA, CMS, SSA); nearly 50 percent of all US hospitals; 26,000 medical groups; and, more than 3,400 dialysis centers. In addition, vendors are increasingly collaborating directly to achieve effective interoperability across disparate products and health IT systems.
- **Value-based payment and delivery system reform is the biggest driver of interoperability.** The use of EHRs and health IT are critical to providers' success in new alternative payment models (APMs) driving the delivery of high quality, cost-efficient, coordinated care. As value-based payment and delivery system reform also requires extensive data sharing across providers and patients, these initiatives are the primary drivers to enable interoperability across EHRs and health IT in general, and for providers to use and demand further interoperability. A good example of such a reform underway is CMS's new [Comprehensive Primary Care Plus \(CPC+\) program](#), a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based, multi-payer payment reform and care delivery transformation. Interest in this program and others has increased significantly, as providers understand the importance of such cooperation and exchange to both care delivery and their bottom lines. With these changes, health IT customers will provide guidance to vendors and make requests for new functionality as their interoperability requirements evolve.

- **There is now a workable definition of interoperability enshrined in federal law as a consequence of the MACRA legislation of 2015, as well as federal government expectations (and associated policy initiatives) for “widespread interoperability” by 2019.** Under MACRA, [interoperability is defined](#) as the ability for two or more disparate health technologies to exchange clinical information, and to use that information under a standard set of guidelines to coordinate patient care, ultimately improving patient outcomes. Recently, per MACRA, ONC sent Congress a set of planned metrics and measurement strategies to measure interoperability relative to this definition in order determine if the goal of “widespread interoperability” is successfully achieved by December 31, 2018.
- **To remain ONC-certified, EHRs must adopt extensive and increasingly stringent standards-based interoperability features, and providers are under growing pressure from federal payment and incentive programs to use these features to achieve interoperability.** Both the 2014 and 2015 editions of certified electronic health record technology (CEHRT) require extensive standards-based interoperability, with [84 percent of hospitals](#) using the 2014 edition in 2015 and vendors already well underway to achieve 2015 edition certification.
- **The new HL7 [Fast Healthcare Interoperability Resources \(FHIR\)](#)<sup>®</sup> standard is being rapidly adopted** to improve the exchange, integration, sharing, and retrieval of health information based on private sector investment rather than specific regulations requiring its use.
- **Companies adopting the [EHR Developer Code of Conduct](#) put forward by the EHRA commit that they do not block information sharing, a concept that is somewhat theoretical in nature and often not defined precisely.** More than twenty companies, including companies that are not EHRA members, have adopted the EHR Developer Code of Conduct, which explicitly describes how those organizations will support interoperability. In signing onto the Code, members pledge that:
  - We will enable, to the greatest extent possible, our clients to exchange clinical information with other parties involved in the care of a patient, including those using other EHR systems, through standards-based technology.
  - We will be transparent, to the greatest reasonable extent, with clients regarding pricing and costs to our clients related to interoperability products and services that we offer.
  - Given our strong support for interoperability, adherents to the Code do not engage in data blocking.
- **Failures in EHR technical interoperability capabilities can be addressed by ONC through existing certification and decertification levers.** Under the current health IT certification program, ONC has the authority to certify and decertify EHRs and other health IT products. In the past, ONC has, in fact, used this authority to [decertify products](#) for various reasons.

- **The US Federal Trade Commission (FTC) already has the authority to [regulate competition](#) in the health IT marketplace, has stated it is “well-positioned” to do so, and is currently actively monitoring the industry.** “The FTC [U.S. Federal Trade Commission] is well-positioned to monitor competition in today’s burgeoning health information technology (IT) marketplace, ...relying on our combined expertise in healthcare, technology, and health-related privacy and data security issues...FTC staff, together with our ONC partners, will continue to pay close attention to developments in health IT markets.”
- **There are multiple private rating and evaluation systems for EHRs in place now.** There are a number of private sector resources that provide commentary and rankings of EHRs and other health IT, including the American College of Physicians’ [American EHR website](#), the [Black Book Rankings](#), [Gartner](#), the [HIMSS Analytics EMR Adoption Model](#), and [KLAS](#), among others.

We have seen, ironically, that state health information exchange organizations (HIEs) can sometimes act as a barrier to interoperability because of costs imposed on providers or the use of nonstandard functionality. While there is a place for HIEs to add value, such as we see with the Surescripts network and some state or regional HIEs, many state HIEs have not accomplished what they set out to do. We encourage all states, when considering how they might enhance interoperability among their provider organizations, to evaluate opportunities to both reduce the barriers to exchange, to the extent that HIEs create such barriers and also to recognize and support alternative means to exchange and interoperability outside of an HIE, including applying and more fully utilizing the standards that certified EHR vendors already must support. State level programs that build on the nationally-required set of interoperability standards can gain more rapid adoption and expansion, as far less incremental work would be necessary to implement and deploy the desired interoperability. One method that we discussed with other states is to have physicians include their DIRECT addresses when updating their demographic profiles as may be required by state licensure. If the state then made available a file of addresses for vendors to download, the dissemination of these addresses into directories could facilitate exchange using the DIRECT protocol, already required of the meaningful use and MIPS programs.

Several states have mandated e-Prescribing of Controlled Substances (EPCS). While we are not recommending these mandates, if your state chooses to follow that path, it is important not to require additional reporting or audits beyond those mandated by the Drug Enforcement Agency (DEA), so as to leverage currently-available EHR functionality. Additional requirements would slow the uptake rather than accelerate it, as additional software development would be needed.

We have heard many complaints about state prescription drug monitoring programs (PDMP) requiring additional sign-on rather than allowing single sign-on via the EHR. Some states have successfully partnered with a third party technology partner that allows EHRs to connect directly, making the process more efficient and therefore more likely to be used. Appriss is one such vendor that many states are using and that EHR vendors already support.

We will continue to participate in the dialog on this important topic, both at the state and national levels, and look forward to working with all stakeholders to educate provider executives,

physicians, and legislators as we collaborate to achieve this important goal. The EHR Association recognizes that increasing interoperability both locally and across communities is essential in achieving our shared objectives of a more efficient, effective healthcare system for all Americans.