AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

April 18, 2013

Farzad Mostashari, MD, ScM
National Coordinator for Health Information Technology
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: Interoperability RFI
Hubert H. Humphrey Building, Suite 729D
200 Independence Ave. SW
Washington, DC 20201

Re: Advancing Interoperability and Health Information Exchange

Dear Dr. Mostashari:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 105,900 family physicians and medical students nationwide, I write in response to the request for information on Advancing Interoperability and Health Information Exchange as published in the March 7, 2013 *Federal Register*.

In this regulation, the Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS) seek input from the public on a series of potential policy and programmatic changes to accelerate electronic health information exchange across providers.

As a strong supporter of electronic health records (EHR) and health information exchange (HIE), the AAFP appreciates this opportunity to provide comments. Following the specific questions posed by ONC and CMS are the AAFP's responses to questions pertinent to family physicians:

1. What changes in payment policy would have the most impact on the electronic exchange of health information, particularly among those organizations that are market competitors?

As implemented through the Electronic Prescribing (eRx) Incentive Program, enhanced payments for clinical processes and quality improvement efforts at the point of care are effective in successfully motivating physician and provider compliance. Incentivizing the

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sharing of clinical data at the point of care could present a key opportunity for CMS to expand the exchange of health information by physicians.

The AAFP appreciates the need for blended payment models to balance various health care stakeholder needs. Implementation and expansion of value-based payment models focused on better quality and efficiency will likely reinforce the sharing of data and the building of infrastructures that support such models.

The AAFP considers patient-centeredness to be a core component of the patient centered medical home and patients having access to their health information is consistent with that approach to health care. By covering the operational costs of a patient portal, allowing patient-consented access to their complete health story at any time, CMS can support both physician and patient to share data at the actual point of care. CMS also should help patients manage their health story through adjustments in insurance copayments, deductibles, and coinsurance (shifting these costs to the insurance plan) for encounters that are preceded by clinically relevant Directed Exchange.

Though the AAFP encourages CMS to consider a number of potential strategic changes for payment policy, such changes inevitably will require that ambulatory practices make significant investments of financial, intellectual, and human capital. Therefore, the AAFP calls for payment adjustments that provide substantial incentives in a multi-plan approach to drive practice-level change . This multi-plan method would affect a greater majority of patients within a practice, not just the practice's Medicare or Medicaid patients.

2. Which of the following programs are having the greatest impact on encouraging electronic health information exchange: Hospital readmission payment adjustments, value-based purchasing, bundled payments, ACOs, Medicare Advantage, Medicare and Medicaid EHR Incentive Programs (Meaningful Use), or medical/health homes? Are there any aspects of the design or implementation of these programs that are limiting their potential impact on encouraging care coordination and quality improvement across settings of care and among organizations that are market competitors?

The AAFP considers the patient centered medical home, where financial incentives motivate a focus on patient outcomes, to be making the greatest impact on establishing infrastructure for clinical (and administrative) data sharing. Extension of PCMH precepts to the medical neighborhood and accountable care organization (ACO) concepts also should rapidly advance HIE , though actual utilization is not yet well documented. Programs that focus on structure, such as requiring certification, or processes requiring accreditation or recognition, do not appear to have yet significantly influenced the multi-stakeholder environment of clinical data sharing. The AAFP remains concerned, however, that ACO efforts may be at significant risk of establishing data-sharing tools and policies that are not conducive to exchange across market competitors.

With changes to EHR certification requirements for stage 2 meaningful use in 2014, certified EHR technology should significantly improve functionality and allow family physicians to share clinically relevant data sets through mechanisms that are compatible with optimized clinical workflows. Since CMS EHR Incentive program payment per eligible professional (EP) for stage 2 is significantly less than for stage 1, the AAFP strongly urges ONC and CMS to ensure that the cost for technical compliance with meaningful use does not become progressively larger as the incentives become progressively smaller.

Achieving quality improvement across a variety of care settings is a difficult but worthwhile task. Physicians must be held accountable for care provided to their patients and thus should be expected to continuously improve the delivery of care. However, the AAFP is concerned that physicians could be held accountable for the actions or inactions of organizations and individuals beyond the physician's scope of control or even influence. That said, the AAFP still believes it worthwhile to incorporate data from external sources to assure the practicing physician is providing appropriate care.

3. To what extent do current CMS payment policies encourage or impede electronic information exchange across health care provider organizations, particularly those that may be market competitors? Furthermore, what CMS and ONC programs and policies would specifically address the cultural and economic disincentives for HIE that result in "data lock-in" or restricting consumer and provider choice in services and providers? Are there specific ways in which providers and vendors could be encouraged to send, receive, and integrate health information from other treating providers outside of their practice or system?

The current predominance of fee-for-service payment models linked with patient expectations for acute, problem-based care encourages increased volume of health care services. We believe the electronic and timely receipt of complete prior records is likely to reduce inefficient utilization. This improved efficiency could reduce established revenues for some providers. Additionally, the misconception that a given health care organization should possess health information about any given patient that no other providers may access is used to guarantee patient loyalty to given health care institutions. The AAFP believes such business models must be reengineered to enable systematic improvements in quality, safety, and efficiency. The AAFP strongly supports a development focus on transport, scalable trust, and interoperable data representation bound to a commitment for exchange not only between health care providers but among patients, families, and providers.

The management of a panel of patients does not start and stop at the front door of the primary care clinic. As data is shared, so is responsibility for improving quality and clinical outcomes. Though the AAFP believes that the availability of a patient's complete health story at the point of care is essential to effective, efficient, patient centered care, our broken health care system may benefit more immediately, if incrementally, through encouraging clinical data sharing for population management and quality improvement.

The AAFP encourages CMS to allow meaningful use and PQRS measures to be fulfilled with information obtained through data sharing, health information exchange (HIE), and secure clinical messaging. Dentists and optometrists are checking patients' blood pressures not because it is clinically relevant for a typical visit, but because meaningful use requires it. We urge ONC and CMS to allow eligible professionals (EPs) to use data obtained through HIE to meet such a measure. If the family physician has checked a patient's blood pressure in the last year and forwarded that result, it should be available to another EP for meaningful use and PQRS reporting. If the blood pressure has not been checked, policy should allow, for example, the dentist to send a clinical message back to the family physician requesting the evaluation and allow that request to meet the meaningful use requirement for that dentist. A side effect of this practice is the development of a "chain of quality" across care teams. If primary care physicians who consult with subspecialists are high performing in reporting quality measures, less is needed from the subspecialist to bring patients into quality compliance. If primary care physicians requesting a subspecialist's consultation are low performing on quality measures, then the subspecialists would need to bring those patients into quality compliance or provide notification to the primary care physicians about the actual gaps in quality, rather than just sending generic reminders of broad compliance requirements.

6. How can CMS leverage regulatory requirements for acceptable quality in the operation of health care entities, such as conditions of participation for hospitals or requirements for SNFs, NFs, and home health to support and accelerate electronic, interoperable health information exchange? How could requirements for acceptable quality that involve health information exchange be phased in overtime? How might compliance with any such regulatory requirements be best assessed and enforced, especially since specialized HIT knowledge may be required to make such assessments?

Several Medicare and Medicaid initiatives are appropriately focused on outcomes that promote the triple aim, which is to improve the patient experience of care, improve the health of populations, and reducing the per capita cost of health care. Insomuch as HIE helps achieve these outcomes, it will expand appropriately across organizations and out into the broader medical neighborhood. Such initiatives, however, must not only require participants to implement HIE and data sharing tools as a purely structural and process measure, but also must enhance use of the HIE technology and policies to improve those outcomes for which participating providers are accountable. Though HIE is an essential technology and technique that must be incentivized to improve quality and cost issues, CMS also must promote desired outcomes by allowing clinicians to adopt whatever tools they deem necessary to fulfill triple aim expectations. HIE may be fundamental but its deliverable must be available, accurate, and actionable data. The consistent application of Direct protocols and standards will help assure the availability of an array of HIE tools tailored to the needs of individual providers and their patients.

7. How could the EHR Incentives Program advance provider directories that would support exchange of health information between Eligible Professionals participating in the program. For example, could the attestation process capture

provider identifiers that could be accessed to enable exchange among participating EPs?

Data sharing through HIE is of benefit to all providers even those that have not attested to meaningful use. At a minimum, Medicare/Medicaid participation, rather than meaningful use participation, would be a better inclusion criterion for provider directories. The AAFP advocates for all health care professionals to obtain a single, identity-verified Direct address or credential that could be used by federal, local, and private programs to support provider directories and the secure and consented exchange of health information.

8. How can the new authorities under the *Affordable Care Act* for CMS test, evaluate, and scale innovative payment and service delivery models best accelerate standards- based electronic HIE across treating providers?

Federal and state HIE activities have focused on transitions of care and subspecialty referrals. The patient centered medical home (PCMH) offers significant data-sharing opportunities that may provide manageable and scalable starting points to system-wide behavior change. The AAFP continues to consider team care is a core component of the PCMH, which requires enhanced information management techniques to establish treatment goals and appropriately plan and optimize care. Though some PCMHs are integrated with a single, shared EHR system, other virtual teams are limited by a lack of data sharing. The data requirements of such PCMH care teams are much more generalizable than the specialized data needs of various subspecialty care providers. This content is much more manageable for IT systems and specifications and could represent an extendable core as the value of data sharing is more clearly exemplified. Additionally, the GP2GP programs in the United Kingdom and New Zealand have been those countries' most successful HIT projects, instantly moving complete medical records from one primary care practice to another upon patient request, which allows participating primary care physicians to have a complete medical record for every "new" patient in their office. Such record transfers impact up to 10 percent of the entire populations of those countries.

Family physicians have been key participants in EHR adoption and meaningful use in the United States for decades. A specialty-wide commitment to the PCMH positions family physicians to lead by example through data sharing initiatives that directly improve clinical care.

9. What CMS and ONC policies and programs would most impact patient access and use of their electronic health information in the management of their care and health? How should CMS and ONC develop, refine and/or implement policies and program to maximize beneficiary access to their health information and engagement in their care?

The AAFP considers the Blue Button initiative and other efforts that encourage mobile and desktop application development to be desirable paths. We believe internet-based

availability of standardized access, content models, and processes are essential for widespread patient engagement. We support multiple content models since they are imperative for enabling multiple use cases in patient engagement. The AAFP encourages ONC and CMS to examine policy options for providing a standardized, practice-managed portal solution for patients and their families. Even if such an offering where to provide little more than authorized access controls and implementation of the Blue Button, the impact on patient engagement and data liquidity would be substantial on a national scale.

10. What specific HHS policy changes would significantly increase standards based electronic exchange of laboratory results?

- Through CMS' position as an insurance plan, requirements could be set for all labs to map their proprietary terminologies to Logical Observation Identifiers Names and Codes (LOINC), making that encoding available on all laboratory tests/results of Medicare/Medicaid beneficiaries.
- We believe that the verification of unique patient identity remains a significant barrier to aggregation of available health data for a single patient. The AAFP urges privacy and security policies that support unambiguous patient identification as a way to safely support health data sharing, collaborative clinical decision-making, and care coordination efforts.
- Access to test ordering and results through laboratory managed standardized application programming interfaces (APIs) with appropriate user credentials would avoid the current morass of one-off laboratory to EHR system interfaces and substantially reduce implementation, maintenance, and usage costs for practices, particular small practices.

In closing, as supporters of EHRs and HIE, we hope these comments are useful for ONC and CMS and we appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Jason Mitchell, MD, the AAFP's Director of the Center for Health IT, at 913-906-6000 ext. 4102 or jmitchell@aafp.org.

Sincerely,

Glen Stream, MD, MBI, FAAFP
Board Chair