AMERICAN ACADEMY OF
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June 3, 2016

Karen DeSalvo, MD, MPH, MSc
Acting Assistant Secretary for Health
U.S. 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., Room 7025A
Washington, DC 20201

Dear Dr. DeSalvo,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write in response to the request for information regarding assessing interoperability for the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) as published by the Office of the National Coordinator for Health Information Technology (ONC) in the April 8, 2016 *Federal Register*.

The AAFP appreciates the opportunity to work with ONC toward achieving these goals and have the following responses to ONC's questions in this regulation.

Scope of Measurement: Defining Interoperability and Population
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 AAFP believes that to achieve "widespread interoperability" a consistent and uniform measurement process is needed. Such a process would enable measurement of interoperability broadly across the entire health care ecosystem. For the purpose of continuity of care, care coordination, and the standard of care for any given care encounter, physicians and healthcare providers who are meaningful EHR attesters must exchange information with non-meaningful users who have not yet attested to Meaningful Use, MACRA, the Merit-based

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Incentive Payment System (MIPS) or an Alternative Payment Model (APM). For this reason, it does not make sense to limit the focus of measurement to only those who are meaningful EHR users. A calculated measurement of the achieved percentage of interoperability across the U.S. which does not include many long-term care facilities that are not yet meaningful EHR users does not reflect an accurate view of the status of interoperability within the health care ecosystem.

Rather than to propose various measures and means of measuring “widespread interoperability” among different user groups (like meaningful EHR users, non-meaningful EHR users, and long-term care facilities), the AAFP would instead recommend that measuring interoperability be harmonized into a single process to reduce administrative burden.

Measuring interoperability is highly complex and challenging. It is crucial to understand what the focus of measures should be. As with all endeavors in health care, patients should lie at the heart of all efforts. Thus, interoperability measures should be patient-centric, with continuity of care and care coordination as the focus of measures identified to enable measurement of interoperability. Even with a focus on measures tied to continuity of care and care coordination, measuring interoperability is a complex task for which a few guiding principles should be adopted:

- Measures should be patient centric and promote coordination of care
- The measures should not add administrative burden to clinicians or their practices, and
- Multiple data sources should be utilized to measure interoperability.

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).
Appropriately so, it does not appear that interoperability requirements are grossly different for eligible professionals within MIPS versus APM payment models. If this is the case, we would recommend that the measurement process for interoperability be consistent across both programs.

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?
To adequately answer this question, it is important first to articulate clearly the goals of interoperability in order to gauge how to measure it (i.e., which aspects should be measured). The AAFP believes there are at least three key goals that interoperability needs to enable efficiently and effectively:

- Improved continuity of care
- Improved care coordination
- The ability to change out or substitute health IT systems

For the goal of improving continuity of care, the identified various components of interoperability ONC intends to measure (i.e., electronic sending, receiving, finding and integrating data from outside sources, and subsequent use of information electronically received from outside sources) seem appropriate.

For the goal of improving care coordination, those identified components are needed; however, additional components are needed, including: verifying and managing identities, and ensuring appropriate authentication and authorization of entities (i.e., individuals and health information systems).

For the goal of enabling change out or substitution of health IT systems, a more global measure is likely required because of the complexity and variability in interoperability requirements to successfully change health IT systems.

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?
The AAFP believes that to achieve "widespread interoperability," we need a consistent and uniform measurement process in health care for interoperability. For that reason, it does not make sense to limit the focus of measurement to certified EHR technology only.

While we believe the measurement should include all health IT, we are not suggesting that all health IT must go through the same level of certification.

Measures Based upon National Survey Data
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?
Again, it is appropriate and responsible, as one of the two key guiding principles over the measurement of interoperability to use multiple data sources to measure interoperability. As such, while it is important to look to claims data to gauge measurable interoperability, it is also imperative to use survey data that expresses physician and provider perspectives on the key components of interoperability (the ability to exchange and use data) for the purpose of improving care and care outcomes.

While data from the National Center for Health Statistics (NCHS) within the National Electronic Health Records Survey (NEHRS) does provide physician and provider perspectives regarding interoperability and is one appropriate survey source for measuring interoperability, physician and provider perspective data should be sought from additional survey sources as well. Specifically, surveys conducted and reported by all medical specialty societies should be included, as well as survey data from AmericanEHR.com. It is responsible and prudent to invest the time to gather and incorporate this recommended survey data into the process adopted for the assessment of interoperability. The perceptions of physicians and providers, as front-line users of the technologies intended to enable interoperability, provide context and meaning to the otherwise cold and meaningless numerical measurements of the current percentage of interoperability achieved.

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)?
It is difficult to answer this question. Due to the low percentage of total office-based physicians that are meaningful users and that the meaningful user population has a higher percentage of

early adopters and leading organizations, it may be reasonable to assume that one could use office-based physicians as a proxy only in the sense that a measure in the office-based physician population would likely be lower (in regard to advanced interoperability) than that of the meaningful user population.

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?
Yes, national surveys that convey physician and provider perspectives regarding technology functionality and interoperability do provide contextual information required to glean meaning from otherwise meaningless numerical statistics of the percentage of interoperability achieved, or failed to be achieved, to date.

When a nation of physicians and providers is interested, most particularly, in the many positive outcomes possible from the promise of interoperable health information exchange, yet is overwhelmingly frustrated by the lack of technology which meets their natural workflows and needs to achieve desired interoperability, it is prudent and responsible to look to multiple national survey sources that provide physician and provider perspectives. Physician and provider perspectives are key to understanding what is and is not working and what these front-line users of technology recommend can be done to improve functionality aimed at achieving interoperability goals.

As noted in response to question 5, while data from the National Center for Health Statistics (NCHS) within the National Electronic Health Records Survey (NEHRS) does provide physician and provider perspectives regarding interoperability, and is one appropriate survey source for measuring interoperability, physician and provider perspective data should be sought from additional survey sources as well. Specifically, surveys conducted and reported by all medical specialty societies should be included, as well as survey data from AmericanEHR.com.

CMS Medicare and Medicaid EHR Incentive Programs Measures
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 AAFP believes it is important to understand that “adequately address” will have a different definition as the nation progresses in the measurement of interoperability. We believe that today these potential measures do adequately address the exchange component of interoperability. As the nation determines what is adequate in the measurement of interoperability, we must consider the burdens on clinicians and their practices in reporting measures data. We do not want to siphon off resources from patient care to fulfill the documentation requirements of the measures. We do believe, though, that the standard of “adequately address” will become more demanding as we better understand our national level of interoperability and we have better methods of measurement.

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?
Significant technology development work remains to be done regarding reconciliation-related measures. At this point in time, technology tools do not sufficiently exist which enable patients and providers to make efficient and seamless work of the task of reconciliation of exchanged electronic health information. Accessible online and mobile platforms do not yet widely exist that

meet the dual purpose of both patient-facing and clinician-facing needs. Technology developers should invest in deployment of e-tools that allow efficient aggregation, reconciliation, sharing and use of compiled health information to support more timely and effective decision-making. Therefore, while theoretically reconciliation-related measures could, at some point in the future, serve as proxies to assess incorporation and use of exchanged information, it is inappropriate at this stage, given the dearth of available technology that is successfully enabling efficient reconciliation and use of combined or integrated data, to focus on or expand requirements for the use of exchanged information.

10. 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 be available for eligible professionals under the Medicare EHR Incentive Program?
If ONC were to develop measures to evaluate the progress of interoperability across health care providers, the AAFP recommends that the measures be focused on care coordination. These are measures which would be welcomed, because clinicians are already accountable for coordinating care with other clinicians, but are struggling with expectations to use health IT to coordinate care with clinicians outside of their own practices, and within the greater community. Assessing the capabilities of health IT and health information exchange to facilitate care coordination among clinicians is a useful measure. Ongoing monitoring of progress toward interoperable exchange of information for the purpose of care coordination will inform government agencies and health IT developers as to resource investments required for this purpose.

However, measures outlined for this purpose must not create administrative burdens for clinicians which divert efforts that should be focused on coordination of care. Health IT adoption is well underway, and utilization of health IT is the only means of achieving, efficiently and effectively, the desired outcomes which value-based payment rewards. Therefore, it is time to move forward and drop health IT utilization measures. Because of current law, we understand that CMS cannot completely abandon health IT utilization measures. However, we do believe that CMS can significantly reduce administrative complexity and burden while complying with current law. The AAFP recommends a new construct for addressing interoperability issues and the advancement of care information that is a desired outcome of interoperability.

- First, we recommend that the certification process be improved to:
    1. Increase the testing requirements for interoperability; namely, care transitions, secure messaging, and APIs,
    2. Increase the testing around support of the common core clinical data set and its integration in the EHR technology, and
    3. Perform both bench and field testing of CEHRT to ensure these capabilities are available in the market place and can be deployed at the practice/hospital site.

- Second, ensure all the data associated with interoperability measures is reportable via EHR submission or other electronic submission mechanism and does not require physician or clinician documentation and burden to report.

Identifying Other Data Sources to Measure Interoperability

11. 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?
Given the complexity of interoperability and the lack of definitive data measuring interoperability, it would seem that having multiple data sources would be a benefit. These measures from multiple data sources could be accumulated into a dashboard to give a picture of the level of interoperability and the trend over time.

Yes, a combination of measures from CMS EHR incentive programs and national survey data of hospitals and physicians would be appropriate. However, as strongly emphasized previously, measures selected should be focused on continuity of care and care coordination, with the goal of avoiding unnecessary administrative burden. The national survey data gathered and displayed, to provide context to results observed, should include multiple data sources rather than strictly NEHRS and NAMCS survey data. It is imperative that physician and provider perspectives present within other national surveys are incorporated as well, to obtain a 360-degree view of front-line user perceptions about the ability of current functionality in technology to meet interoperability needs and goals.

12. 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?
ONC could leverage the Medicare claims data similar to how Docgraph (www.docgraph.com) has used the subset of data made publicly available. ONC could use the claims to identify networks of physicians and hospitals that are caring for the same Medicare beneficiaries. These graphs of health care providers could then be levered to either identify entities for focus groups or additional surveys around interoperability or filter existing data to understand the level of interoperability within these networks. For example, ONC could identify networks that have a high number of common patients and networks that have a low number of common patients. These could allow ONC to see how interoperability is progressing in these two scenarios. One would assume that the network with a high number of common patients would have incentives in place to invest in infrastructure to drive interoperability, whereas the networks with a low number of common patients would be a better representation of the general, wide-scale level of interoperability. This data could also help ONC identify specific instances of transitions of care where follow-up survey or other data could be gathered to measure the level of interoperability in those transitions.

13. If ONC seeks to limit the number of measures selected, which are the highest priority measures to include?
The ability to narrow the focus of interoperability measures to those of most immediate importance is appreciated. If interoperability measures are prioritized, while continuity of care is important, this is already occurring. Care coordination, however, is an area that clinicians struggle with, especially when required to coordinate care efficiently with clinicians outside of their own practice or within the larger community. The AAFP recommends that measuring actual progress toward interoperability across disparate systems and across clinicians for the purpose of care coordination should receive highest prioritization among measures. Again, administrative burden must be avoided to allow clinicians to focus their time on coordinating care rather than measuring the level of progress toward interoperability in care coordination.

14. 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 recommend the definition of widespread include all entities in the health care ecosystem that need to exchange information to support continuity of care and care coordination. This should include both breadth in the number of entities participating routinely in exchange, as well as depth in the number of transitions of care, where timely and effective information exchange is demonstrated to have occurred.

The AAFP appreciates the opportunity to provide this feedback. Should you have questions, please contact Steven E. Waldren, MD, MS, Director, Alliance for eHealth Innovations at 1-800-274-2237, extension 4100 or swaldren@aafp.org.

Sincerely,

Robert L. Wergin, MD, FAAFP
Board Chair