ACP®
American College of Physicians
Leading Internal Medicine, Improving Lives

June 2, 2016

The Honorable Karen DeSalvo, MD, MPH, M. Sc.
Acting Assistant Secretary for Health,
National Coordinator for Health Information Technology,
Department of Health and Human Services
Attention: ONC 2016-08134
Submitted electronically to: http://www.regulations.gov

**Re: Request for Information Regarding Assessing Interoperability for MACRA**

Dear Dr. DeSalvo:

On behalf of the American College of Physicians (ACP), I am writing to share our comments on the Request for Information (RFI) Regarding Assessing Interoperability for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The College is the largest medical specialty society and the second-largest physician membership organization in the United States. ACP members include 143,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP appreciates the hard work by the Office of the National Coordinator for Health Information Technology (ONC) staff to establish metrics to determine if the objective under MACRA – to achieve widespread exchange of health information through interoperable certified electronic health record (EHR) technology – has been met. **However, the College has concerns with ONC's proposed measurement approach and urges ONC to consider the following recommendations for more useful measures:**

- Measure testing and study frequency in claims data for duplicative services among similar risked-adjusted patients, where multiple clinicians provide care.
- Consider surveys of clinicians and patients asking simple questions about whether needed information was accessible and if not, why not. These measurements do not have to include large numbers of clinicians in order to be valid. Statistically valid samples will meet the need while keeping the costs and effort relatively low.

- Consider measures of care coordination and resource use focused on measuring whether patients received their data, and did they feel that their doctors received and used their data. This could be done through the use of patient satisfaction survey data that could look at a very common set of questions that patients have, such as:
  - "Did you receive a report from Dr. X?"
  - "Did you see that Dr. Y changed my medication for ABC?"

The following outlines ACP's specific comments on the questions and proposed measures listed within the RFI.

## Scope of Measurement: Defining Interoperability and Population

**Background:** In order to establish metrics that will assess whether, and the extent to which, widespread exchange of health information through interoperable certified EHR technology nationwide has occurred, ONC needs to first define the scope of measurement.

*ONC Question: 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?*

> **ACP Comments:** The most important piece to measure is how information is used to improve outcomes and value of care – and that requires broad measurement. Since the population of eligible professionals (EPs) who successfully attested under the EHR Incentive Program is not representative of all of the clinicians who provide health care, limiting measurement to that group will not provide ONC with all of the necessary interoperability information. The College recommends focusing on patients and all of the clinicians providing their care. Support for measurement is not support for thresholds.

*ONC Question: 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).*

> **ACP Comment:** The College believes that EPs under MIPS or APMs should be treated the same, as well as other participants being measured, such as laboratories, pharmacies, and other services.

*ONC Question: 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?*

> **ACP Comments:** The College does not believe that electronically sending, receiving, finding, and integrating data from outside sources, and subsequent use of information electronically received from outside sources adequately address both the exchange and use components outlined in MACRA. Measurement of interoperability should focus less on the actual movement of data from one place to another, and more on measures that actually matter, such as:
> - Reduction in redundancy of tests and diagnostic studies;
> - Improvement in quality measures which are dependent on structured data that exists somewhere outside of the EHR system of the clinician being measured; and
> - Clinician and patient satisfaction with care and the care process (e.g., In web-based commerce sites, frequent survey questions include: "Did you find everything you were looking for?" and "Was the experience pleasing, helpful?"). With the current negativity towards EHRs, it would be very useful to have an initiative that explicitly focused on simplifying one's work – rather than layering on additional requirements. Payers typically collect patient experience and outcome data that could be integrated with other measures immediately.

***ONC Question:*** *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?*

> **ACP Comments:** The College recommends a broader focus of measurement to include the use of certified EHR technology, the use of health information technology (health IT) not subject to certification, and – as discussed above – the effectiveness of interoperability in achieving the goals of better care, safer care, and care that is more affordable. The inclusion of the full range of health IT, such as systems supporting laboratories and pharmacies is important in order to collect information within an area of health information exchange and use that is not well known or understood.

> In all of its measurement activities, it is critical that ONC distinguish measurements of interoperability within an organization that shares a common health IT platform from measurements across multiple organizations that do not share a platform. To a large extent, interoperability has been "solved" within some leading organizations, while interoperability hardly exists at all in interactions among many other organizations. The ACP believes it is worth learning from organizations in which there are few, if any, remaining interoperability challenges, to see if care has been made more efficient and more effective. ONC needs to be collecting evidence of value as well as evidence of data movement.

**ONC's Available Data Sources and Potential Measures - Measures Based upon National Survey Data**

**Background:** Using the national survey data from the American Hospital Association (AHA) Health IT Supplement Survey and the National Electronic Health Record Survey, ONC is considering the following measures below for both hospitals and office-based physicians.

*ONC Proposed Measure: Proportion of health care providers who are electronically sending, receiving, finding, and easily integrating key health information, such as summary of care records. This can be a composite measure (engaging in all four aspects of interoperable exchange) or separate, individual measures.*

> **ACP Comments:** This measure is framed carefully, using the phrase "... such as summary of care records."  Most clinicians find the existing mandated summary of care records bloated, cumbersome, and largely useless.  A lot of potential benefit from interoperability would be missed if ONC and the Centers for Medicare and Medicaid Services (CMS) only looked at the summary of care record. If ONC is to signal that it is measuring the movement of useless clutter, the result will be more movement of clutter. Experience with the exchange of summary of care documents has clearly demonstrated the lack of value in exchanges of lists of previous labs, other procedures, and long-discontinued medications, for example. A key reason to have an interoperable health system is not just to push data points back and forth, but to make accessible what is needed for better and more value-laden care.
>
> Unstructured data, even in a summary of care record, may be the primary source of useful information from one physician to another. If measurement is to reflect the service and care of the patient, and not of the document structure, the question needs to be carefully reframed to ensure that we are not simply counting documents.
>
> Further, while it is easy to measure electronic document "send" and "receive," a determination of "ease of integration of key health information" is a measure of perception, and one that is further subject to individual interpretation of "easily" and "key health information."  For example, it is now widely recognized that one of the reasons why physicians find EHRs cumbersome is that EHRs shine a bright light on activities that may not have been required previously and/or were not routinely done, such as routine preventive care and immunizations.  And where an activity was never consistently done before, no matter how elegantly the EHR deals with the issue – physicians are likely to see even a single click as a burden because one click is greater than zero.  Conversely, physicians may answer "yes" to the question of "ease of integration of key information" as their EHR vendor may have built a solution that automates the process.  While this may seem appealing, such a solution solves a simple problem – data level integration – while removing all awareness of the key data entering the system – a recipe for errors of commission and omission. The health IT community needs more experience to determine if the value of adding external data exceeds the risks of automated integration of large quantities of data.

ACP strongly encourages the avoidance of a composite measure. Composite measures are useful where each component is known and mature which is not the case with the measurement of interoperability and the four aspects used to describe interoperable exchange (sending, receiving, finding, and using key health information).

*ONC Proposed Measure: Proportion of health care providers who use the information that they electronically receive from outside providers and sources for clinical decision-making.*

**ACP Comment:** The College believes that this measure could be useful as long as the information that the health care provider electronically receives is broadly defined in the national surveys that ONC proposes to use. However, the ACP is concerned that a simple YES/NO answer might lead to a misunderstanding of the current state of health information exchange. For example, many physicians believe that what they currently receive during transfer of care situations is cumbersome and cluttered with irrelevant information. Finding the kernel of useful information has been compared to "finding Waldo" in a picture puzzle. And yet, we believe that asking physicians if they "used the information for clinical decision making" is adequate. The answer to the question may be "yes;" but a more nuanced set of questions – such as ease of use or finding what was needed without having to resort to questioning the patient or calling the other clinician would be a more relevant and useful answer.

*ONC Proposed Measure: Proportion of health care providers who electronically perform reconciliation of clinical information (e.g. medications).*

**ACP Comments:** Reconciliation should only be studied for specific situations in which it makes sense, rather than clinical reconciliation being viewed as an "all or none" list management. For example, the medication list from a procedural specialist is generally not clinically relevant to a primary care physician, and a requirement to do clinical reconciliation with every receipt of information would add a lot of time and no value. The College recommends adding flexibility to this measure to address measuring what is relevant to a physician's daily practice.

*ONC Question: 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?*

**ACP Comments:** The measures described in this section measure the process of receiving documents and including structured information from those documents into the database. It is not a measure of ease of integrating and using useful information. The ability to share and receive format-mandated note bloat does not equate with the ability to use information to provide better patient care. Determination of which data are relevant and valuable must be returned to the clinicians.

***ONC Question:*** *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)?*

> **ACP Comments:** Including all office-based physicians would be more valid than only looking at successful attesters under the EHR Incentive Program. ACP believes it would be more appropriate to focus on all of the physicians and other clinicians, no matter what their involvement in the EHR Incentive Program, who are involved in the care of specific patients to determine if useful information is being exchanged.

***ONC Question:*** *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?*

> **ACP Comments:** The College does not believe that national surveys provide the necessary information to determine why electronic health information may not be widely exchanged. The fundamental health information need is to determine those situations in which additional information could be useful, and then determine if the information was available or not, and if not, why not. This should be the primary focus of this measurement program.

**CMS Medicare and Medicaid EHR Incentive Programs Measures**

**Background:** Based upon CMS EHR Incentive Programs data, ONC is considering the following measures listed below. These measures could be used to evaluate the exchange and use aspects of interoperability as described in section 106(b)(1)(B) of the MACRA.

***ONC Proposed Measure:*** *Proportion of transitions of care or referrals where a summary of care record was created using certified EHR technology and exchanged or transmitted electronically.*

> **ACP Comments:** This measure indicates compliance with the EHR Incentive Program, and is not a measurement of useful interoperability. EPs have not found this measure to result in useful information exchanges. We have proposed alternative measures elsewhere in this document.

***ONC Proposed Measure:*** *For 2017 and subsequent years, the proportion of transitions or referrals and patient encounters in which the health care provider is the recipient of a transition or referral or has never before encountered the patient, and where the health care provider (e.g., eligible professional, eligible hospital, or CAH) receives, requests or queries for an electronic summary of care document to incorporate into the patient's record.*

**ACP Comments:** This measure is so complex that it would be impossible to determine the denominator. Attempts to implement this measure have demonstrated the difficulties and confusion that result when health care organizations attempt to operationalize these imprecise categorical definitions.

***ONC Proposed Measure:*** *Proportion of transitions of care where medication reconciliation is performed.*

**ACP Comments:** This measure is so complex that it would be impossible to determine the denominator. Attempts to implement this measure have demonstrated the difficulties and confusion that result when health care organizations attempt to operationalize these imprecise categorical definitions. We have found a complete lack of agreement on what should constitute a transition of care. Also, the fact that a transition has taken place does not necessarily indicate that reconciliation is clinically appropriate.

***ONC Proposed Measure:*** *For 2017 and subsequent years, the proportion of transitions or referrals received and patient encounters in which the health care provider is the recipient of a transition or referral or has never before encountered the patient, and the health care provider performs clinical information reconciliation for medications, medication allergies, and problem lists.*

**ACP Comments:** The College does not believe that this measure should be included because the measurement of reconciliation of lists prior to standardization of how these lists are used creates huge burden without benefit.

First, clarification is needed as to what an inclusion in the allergy list means, and how it is recorded. Reconciling an allergy list where one physician follows the narrow ONC definition (just Immunoglobulin E [IgE] mediated responses) with another physician who is documenting allergies and intolerances in the same list would be a pointless exercise. For the purposes of all types of care not provided by allergists, anything that the patient reports as an "allergy" should be included in the list.

The difficulties are worse with problem lists. Physicians use problem lists in different ways, and unless the scope is narrowly defined – perhaps starting with chronic illnesses – this would be very burdensome. Further, is there any literature on the time burden this is likely to add to every office visit? Medication reconciliation adds 1-5 minutes per visit. Making list reconciliation a measurement focus, 10 minutes out of a 15 minute visit could be devoted to list management.

For these reasons, it would be a mistake to conclude that a failure to reconcile problem lists or allergy lists is a failure of interoperability.

***ONC Question:*** *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?*

> **ACP Comments:** Except for reconciliation-related measures, these measures might suggest that we know something about volumes of data moving through the system; however, there is little value to these particular measures as indicators of interoperability. The reconciliation-related measures are not suitable for measuring interoperability, as the tasks can be and are performed accurately without accessing external sources of electronic data.

***ONC Question:*** *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?*

> **ACP Comments:** The College does not believe that the reconciliation-related measures serve as adequate proxies to assess the subsequent use of exchanged information. List management is exploratory and not evidence of quality or interoperability. List management is as likely to occur without external data as it is with external data. It is premature to say that more reconciliation is better than less.
>
> Subsequent use would be better measured by increase in clinician satisfaction with EHRs, as the idea is that receipt of information that is useful and usable should make list management less burdensome and more accurate – but that is not proven. Subsequent use could also be measured by development of a statistically significant measure of redundancy reduction *coupled* with survey data of ease of use.

***ONC Question:*** *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?*

> **ACP Comments:** As the United States focuses more on care of complex patients with chronic conditions who are cared for by multiple physicians, what is important is meaningful information sharing – and not trying to determine if an arcane definition of care transition applies. The focus should be on whether all of the clinicians providing ongoing care to a particular patient are aware of what each other are doing.

## Identifying Other Data Sources to Measure Interoperability - Overarching Questions

***ONC Question:*** *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?*

**ACP Comments:** Limiting oneself to a single source is based on the premature conclusion that that single source is the right source. We are too early in the process to know which sources are likely to prove the most reliable and valid. Comparing results from widely varying sources is likely to be our best way to learn something about where the facilitators and the roadblocks are.

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

**ACP Comments:** The College urges ONC to consider measuring testing and study frequency for similar risked-adjusted patients, where multiple clinicians provide care. Additionally, consider surveys of clinicians and patients asking simple questions about whether needed information was accessible and if not, why not. These measurements do not have to include large numbers of clinicians in order to be valid. Statistically valid samples will meet the need while keeping the costs and effort relatively low.

*ONC Question: 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?*

**ACP Comment:** As stated in the previous comment, ACP urges ONC to consider measuring claims for duplicative testing.

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

**ACP Comments:** The College urges ONC to consider measures of care coordination and resource use. Perhaps use of patient satisfaction survey data that could look at a very common set of questions that patients have, such as:
- "Did you receive a report from Dr. X?"
- "Did you see that Dr. Y changed my medication for ABC?"

ONC should focus on measuring whether patients received their data, and did they feel that their doctors received and used their data.

*ONC Question: 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?*

**ACP Comments:** The College believes that health information exchange organizations (HIOs) should be able to report on the volumes and success rates of clinical data queries. This will not work for health information service providers (HISPs), however, since the Direct protocol does not support pulling information via queries.

***ONC Question:*** *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"?*

**ACP Comments:** Given the impact of the EHR Incentive Program on clinician attitudes and behaviors, ONC must carefully explain that its use of the word "threshold" in its measurement plan is in no way suggesting that clinicians will be held accountable in any way for the level of their information exchange activities. Measurement should inform and not punish. Measurement should not incentivize aberrant behavior to just achieve a threshold.

50 percent seems to be a very low threshold for declaring success. If a clinician is able to find and use needed information only half the time, he or she is unlikely to be motivated to attempt a search at every opportunity. Clinicians will need confidence that conducting a health information search or exchange is highly likely to be beneficial before they make it a routine behavior.

We thank you for the opportunity to provide input on these important issues, and hope that you will find value in our response. Should you have any questions, please contact Thomson Kuhn, Sr. Systems Architect, at tkuhn@acponline.org.

Sincerely,

Peter Basch, MD, MACP
Chair, Medical Informatics Committee
American College of Physicians