April 22, 2013

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National Coordinator for Health Information Technology
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Hubert H. Humphrey Building, Suite 729D
200 Independence Avenue, SW
Washington, DC 20201

Re: Advancing Interoperability and Health Information Exchange

Dear Dr. Mostashari,

The undersigned organizations appreciate the opportunity to submit comments to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on *Advancing Interoperability and Health Information Exchange.*

As the nation's healthcare system is undergoing a transformation in an effort to improve quality, safety, and efficiency of care, the undersigned organizations support ONC and CMS' goal to advance interoperability and health information exchange (HIE). We believe that these efforts can improve care coordination and support new service delivery and payment models. Our comments are presented in the order in which they appear in the RFI.

I. Background

The undersigned organizations value ONC and CMS' goal to achieve widespread interoperability and the electronic exchange of information. However, because eligible professionals (EPs) and eligible hospitals (EHs) are working hard to be compliant with stage 1 of the CMS Electronic Health Record (EHR) Incentive Program, we encourage CMS and ONC **to focus on remedying current challenges** within the program rather than proposing new criteria that may hinder the progress made by providers and hospitals thus far. We are greatly concerned that changes are being sought without considering how providers, especially specialists, have fared with meeting the criteria used in stages 1 and 2 of the EHR Incentive Program. Information needs to be collected, through validated survey methodologies, on how providers are performing before making recommendations for new criteria or increasing reporting thresholds in stage 3 or future iterations of the program. Examples of challenges currently facing EPs in the EHR Incentive Program include the absence of requirements to meet specific needs of certain specialties, the difficulty for many solo and small group practitioners and physicians, some of whom are key providers in underserved areas, or who may be in and near retirement, to invest in and adopt EHRs, and the lack of valuable quality measures for specialists.

The undersigned organizations have continually called for the ability of providers, especially specialists, to use a single set of criteria that simultaneously satisfies the reporting requirements of multiple CMS quality improvement programs. Although CMS is working with the ONC to better align the EHR

Incentive Program with others, such as the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBPM) and shared savings programs, these programs continue to have overlapping and conflicting reporting requirements. CMS and ONC must also work to standardize its timelines for reporting to these various programs. Currently, the timelines, as well as the reporting deadlines, vary, which increases measurement burden and confuses physicians who are trying to participate and receive credit across all Medicare quality programs. Furthermore, the alignment that has begun to occur is not applicable to most specialists due to the lack of relevant measures and reporting requirements. In order to ensure robust compliance and reduce the reporting burden on specialists, it is extremely important for alignment to occur with the various government-sponsored quality improvement programs. This is particularly important given many of these overlapping programs will become punitive in future years, based on data collected in the current year. We therefore encourage the CMS and ONC to continue collaborating on efforts to accomplish this goal.

Moreover, while stages 2 and 3 of the EHR Incentive Program are intended to advance HIE among EPs and EHs, there are still a number of providers who are non-eligible for the program including long-term and post-acute care providers. We believe that CMS and ONC should initially focus on expanding interoperability and HIE among these non-eligible providers rather than changing requirements for EPs and EHs before they can find solutions for existing challenges. Furthermore, it is crucial for CMS and ONC to note that interoperability and HIE will only be valuable to those who are actively participating in the EHR Incentive Program and that there are still a considerable amount of EPs who are not participating in the EHR Incentive Programs. In order to encourage interoperability and HIE among non-participating EPs, it is vital that CMS consider the underlying causes of non-participation of such providers in the EHR Incentive Program and address these causes rather than adding additional requirements.

In addition, the RFI mentions that there is a lack of a "business imperative for providers and vendors to share personal level health information across providers and settings of care."[1] We believe this mischaracterizes the reason that many EPs are non-participatory. As a general matter, the undersigned organizations recognize the potential value of EHRs to improve quality. There are however considerable barriers to its widespread adoption, including high cost, lack of functionality (especially for specialists, who require much more tailored EHR systems), lack of relevant measures in the incentive program, and interoperability challenges. While we agree that implementation of an EHR is resource-intensive and requires a certain level of business calculation, the decision to integrate an EHR into a practice is primarily a clinical decision. Physicians, their practices, and their EHR needs are not homogenous. For many specialists, they have adopted EHRs into their practice but may have chosen not to participate in the EHR Incentive Program due to lack of relevant measures. Many EHR products do not work in a way that meets their patient's needs nor are the EHR Meaningful Use measures collecting information that reflects the data important for providing specialty care. One example can be found in the field of anesthesiology, where anesthesiologists are faced with meaningful use criteria that is inapplicable to their practice. Additional modifications to the meaningful use criteria are needed to ensure that anesthesiologists and other specialists can reasonably achieve meaningful use and share meaningful data. On the vendor side, vendors may be inclined to avoid the added expense of extensive customization, focusing on building models solely based on program requirements thereby only collecting information on a limited set of

[1] Advancing Interoperability and Health Information Exchange. 78 FR 14794 (March 7, 2013)

measures that are not applicable to all specialties, which decreases the value of the products on the market for specialists.

Additionally, the RFI states that "as other value-based payment programs evolve, they might include greater emphasis on HIE as either a requirement for participation, receipt of incentive payment, or avoidance of payment adjustments."[2] The undersigned organizations are not supportive of implementing additional payment penalties, especially given that current programs are in need of significant changes. Physicians are already overburdened with having to meet various quality reporting requirements in Medicare, Medicaid and the private sector. To add an additional layer without fixing alignment will only exacerbate the problem.

One facility setting that has been left out of the EHR Incentive program is the ambulatory surgery centers (ASC) setting. While incorporating ASCs into the HIE framework would be an opportunity worth considering to increase the transfer of valuable information, the undersigned organizations believe that CMS should carefully consider the structure of an ASC and design criteria according to their needs rather than apply meaningful use criteria to ASCs as currently defined for physicians and hospitals. Because of the type of care delivered in ASCs, the current program requirements would likely not be a good fit for ASCs.

As part of a comprehensive effort to advance interoperability and HIE, the undersigned organizations support expanded use of specialty registries as part of Federal programs. Specialty registries may be useful in helping to streamline the exchange of HIE for quality improvement and patient safety, and measures from these registries can be more relevant, clinically appropriate, and actionable for specialists. Particularly for those specialties who have not yet developed registries but are looking to develop the best methods for collecting and reviewing clinical outcomes data and in providing relevant benchmark data on procedures performed by the specialty, which can be utilized to improve performance, it will take significant resources and may take several years for data collection and analysis before improvement in practice can be documented satisfactorily. However, the undersigned organizations believe that aligning registry participation with the EHR Incentive Program is one avenue that will help facilitate strategic HIE and focused quality improvement while achieving value by reducing the reporting burden on the physician community. Allowing specialists to participate through registries that are validated, relevant, and developed and run by specialists will increase participation in these programs.

In terms of interoperability, problems persist not just between physician practices and hospital systems, but also between EHR systems and clinical data registries. We believe that CMS and ONC can, and should, play a greater role in facilitating the use of clinical data registries by encouraging the development of standards for sharing/transmitting data between EHRs and registries. Presently, practices are forced to manually enter data into a registry because no streamlined process exists and because of the proprietary nature of health information technology (HIT) products. This existing data sharing process is particularly challenging for solo and small practices; thus preventing many from participating in registries. Finally, the manual data entry process requires a full-time or half-time employee, which is an added cost that that most practices cannot easily absorb.

[2] Advancing Interoperability and Health Information Exchange. 78 FR 14795 (March 7, 2013)

II. Programs and Policies under Consideration by CMS and ONC

A. Low Rates of EHR Adoption and Health Information Exchange Among Post-Acute and Long-Term Care Providers

The undersigned organizations agree that there needs to be increased HIE and interoperability among post-acute and long-term care providers. We believe that CMS and ONC should initially focus on ways to increase HIE and interoperability among these groups rather than adding to the program requirements that already exist for EPs and EHs. Since EPs and EHs are already facing many challenges with current EHR Incentive Program requirements, **we recommend that CMS and ONC work on finding solutions to existing problems before adding any new requirements.**

The undersigned organizations urge CMS and ONC to carefully consider the option of giving states the flexibility to accelerate HIE by allowing them to implement new delivery and payment models for Medicare and Medicaid beneficiaries. We believe that allowing every state to implement its own delivery and payment models to accelerate HIE, may create a "patchwork system" of programs and models. This could particularly affect physician groups and physicians that practice across state lines. The additional flexibility also increases measurement burden. In addition, the undersigned organizations strive to serve as a resource to our members, so having differing requirements from state to state will make it more difficult for our organizations to create and disseminate educational material to our members. The undersigned organizations work diligently to keep members apprised of all the latest developments in various Federal programs and would like to partner with CMS and ONC as they further expand HIE.

B. Low Rates of HIE Across Settings of Care and Providers

The RFI mentions several possible ways that the Department of Health and Human Services (HHS) can accelerate HIE across providers and settings of care. First, it states that HHS can collaborate in the development of new e-specified measures of care coordination that will encourage electronic sharing of summary records following transitions of care. The undersigned organizations understand the importance of translating measures into being "e-specified." However, we believe that not every measure can be translated into an "e-measure" for technological and/or clinical reasons. Specifically, at the this time, the undersigned organizations are not certain if the stage 2 measure requiring an EP to provide a summary of care record for each transition of care or referral, can be accurately translated into an "e-measure." As such, we recommend that CMS and ONC first analyze the success of this measure under stage 2 of the EHR Incentive program before investing in resources to develop this measure into an e-measure. Furthermore, if patient activity is recorded in future years, it should be used to supplement the medical record and better inform clinical decision making. It should not be used as the basis of determining physician accountability, since EPs do not have direct control over patient actions.

Second, the RFI notes that CMS may want to consider new ways to require Medicare Accountable Care Organizations (ACOs) to exchange health information as a part of care coordination. The undersigned organizations do not support adding new HIE requirements for ACOs as it may be difficult for entities to adapt to future requirements if they are already in the process of trying to develop their systems to meet

existing requirements. We believe that it is better to assess performance and value the requirements after these entities have had a period of several years to function under the current program requirements rather than reconfiguring while they are still mid-course.

Third, under the Affordable Care Act (ACA), CMS has been given the authority to test innovative payment and service delivery models that may help lower expenditures in the Medicare, Medicaid, or Children's Health Insurance Program. The RFI recommends that for such future models under the ACA, CMS can request applicants who apply to participate in these models, to describe how they are using interoperable technology and advancing HIE strategies to support quality improvement and care coordination. The undersigned organizations are generally supportive of this suggestion and agree that it could be included, but the lack of demonstrating interoperability and HIE should not disqualify an applicant since HIE and interoperability may not always be relevant to the program. Applicants should also not be given preference if their program incorporates HIE since HIE may not always be necessary in all delivery reform efforts and programs. Often interoperability is a vendor issue that ONC and CMS need to resolve with the EHR vendor community.

Additionally, one of the biggest challenges to interoperability for image-based specialties is the lack of enforcement around adherence to the Digital Imaging and Communication in Medicine (DICOM) standards for the exchange of images and data among imaging devices, image management systems, and EHRs. Promoting standards-based transmission of patient images is one area in particular where more robust criteria would have tremendous value for physicians, particularly specialists. In the absence of a clear enforcement mechanism for the DICOM standards, many vendors have developed their own proprietary interfaces for the viewing and transmission of image data. This effectively eliminates the ability to transmit data across vendors and often creates the need for manual re-entry of image data.

ONC has made several steps towards interoperability in this area, including an optional meaningful use objective requiring that the physician have the capability to access images through the EHR system. ONC has also awarded an "ocular imaging challenge grant" for the development of an interface to create an interoperable work environment for eye care clinics by standardizing imaging data to DICOM specifications. However, we believe ONC and CMS still have policy levers at their disposal to expand these efforts on a broader scale. ONC could, for example, begin certifying EHR modules for the transmission and viewing of images to DICOM standards, thus ensuring that EHRs and image management systems are DICOM compatible.

C. Low Rates of Consumer and Patient Engagement

CMS would like to encourage beneficiaries to engage in their health care by having access to their personal health information as well as having better electronic communication with their providers. The RFI recommends several options that can help increase consumer and patient engagement in health care, of which the undersigned organizations are generally supportive. However, with regard to adding two new patient engagement measures to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey in the Medicare Advantage Program, it is critical that CMS and ONC take into consideration that CAHPS surveys are developed, tested, and deemed reliable, feasible, and valid based on the original survey developed by CAHPS Consortium at the Agency for Healthcare Research and

Quality (AHRQ). When additional measures are added to the tool, the feasibility, reliability, and validity of the CAHPS survey may be affected.

Lastly, the RFI notes that another option to increase consumer and patient engagement is for CMS to consider providing incentives to consumers who more actively participate in their healthcare through the collection, use, or sharing of electronic health information. While it will be important to further clarify "active participant," the undersigned organizations support this option. As the value of HIE is affected not only by how data is collected, but also by how it is consumed, we believe that this is an important component to further amplify that opportunities increased by HIE for HIE to improve care and outcomes.

The underscored organizations appreciate the opportunity to offer these comments and look forward to continuing to work with CMS and ONC in order to provide additional feedback regarding interoperability and HIE. If you have any questions about our comments, please contact Bob Jasak at 202-672-1508 or bjasak@facs.org.

Sincerely,

American Academy of Ophthalmology

American Academy of Otolaryngology—Head and Neck Surgery

American Association of Neurological Surgeons

American College of Surgeons

American Congress of Obstetricians and Gynecologists

American Society of Anesthesiologists

American Society of Cataract and Refractive Surgery

American Society of Colon and Rectal Surgeons

American Society of Plastic Surgeons

Congress of Neurological Surgeons

Society for Vascular Surgery