AMGA
Advancing High Performance Health

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June 3, 2016

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National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
Humphrey Building
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200 Independence Ave., NW
Washington, D.C., 20201

Dear Dr. DeSalvo:

AMGA appreciates the opportunity to comment on the Office of the National Coordinator for Health Information Technology's (ONC) "Medicare Access and CHIP Reauthorization Act of 2015; Request for Information Regarding Assessing Interoperability for MACRA" (RFI). AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing approximately 177,000 physicians who care for one-in-three Americans. Our member medical groups are interested health information technology (HIT) interoperability for numerous reasons. Our members' are dedicated to leveraging their HIT investments in the most clinically effective and financially efficient way possible to improve the value of their care delivery, or in achieving the triple aim of improving the experience of care, improving the health of populations, and reducing spending or the per capita costs of health care.

Interoperability To Achieve Improved Patient Outcomes

AMGA is moreover interested in the ONC's statement, "MACRA defines interoperability as the ability of two or more health information systems or components to . . . (2) use the information that has been exchanged . . . in order to facilitate coordinated care and improve patient outcomes." This statement echoes Acting Administrator Andy Slavitt's January comments at the JP Morgan conference and subsequent related statements. We are now in the process, Administrator Slavitt stated at JP Morgan, "of ending Meaningful Use and moving to a new regime culminating with MACRA implementation." "The Meaningful Use program," he said, "will now be effectively over and replaced with something better." "The focus will move away from rewarding providers for the use of technology and towards the outcome they achieve with their patients."

Despite these statements, as proposed, MACRA's Merit-based Incentive Payment System (MIPS) Advancing Care Information (ACI) measure does not appear to reflect neither ONC's nor Administrator Slavitt's patient outcome goals. The ACI "base" and "performance" metrics, identified in Tables 6 through 9 in the MACRA proposed rule, remain limited to measuring simply HIT

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functionality. For example, per Table 6, is the eligible professional performing e-prescribing, do patients have electronic access to their medical records, is care coordination facilitated via electronic means, and are patient records shared via health information exchanges (HIEs).

While AMGA appreciates efforts under the proposed MACRA rule to, as Patrick Conway stated at this week's ONC annual meeting, simplify HIT reporting by making it more flexible and less burdensome, the meaningful use goal apparently remains the same. Under the ACI measure, it appears we will continue to do the same thing, measure use. If the goal is also, or ultimately, to "improve patient outcomes" achieving interoperability, though necessary, it is not sufficient. Even if all MACRA eligible professionals, either individually or reporting as a group, had perfect ACI scores, these scores would tell us little or nothing about how, if at all, HIT was used to, again per the ONC, "facilitate coordinated care and improve patient outcomes" or as Administrator Slavitt stated, reward "providers for . . . the outcomes they achieve with their patients." Achieving "widespread exchange of health information," as stated in the RFI's opening paragraph, must mean more than achieving some quantity of electronically-conveyed information or as critics say, achieving some level of digital faxing. It must also mean measuring how HIT interoperability is being leveraged to improve patient care and outcomes.

More specifically, this means measuring to what extent interoperability, or improvements in interoperability or interoperable use, is producing value. Value is defined as outcomes achieved over spending, or here HIT spending. The RFI makes no mention of interoperability enabling or producing value. The recently finalized, "CMS Quality Measurement Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMS)" also includes no discussion of producing value nor does the Health Care Plan Learning Action Network's (HCPLAN) draft "Performance Measurement" white paper.) The word "value" never appears in the ONC's RFI. Singular achievement of interoperability, like singular achievement of some level of quality performance, is not the same thing as, nor a proxy for, achieving value.

Value is the sum of a performance or outcome numerator measured over a spending denominator, or as Michael Porter stated in a recent New England Journal of Medicine essay, "outcomes achieved relative to the costs."1 Measuring performance, or here HIT interoperability or interoperable use, absent calculating value or value improvement is why, for example, MedPAC stated in its June 2014 report to Congress, "Medicare's current quality measurement approach has gone off the tracks" This was because, the commission explained, current quality measurement requirements leave providers with "fewer resources" to "improve the outcomes of care, such as reducing avoidably hospital admissions," or to improve value.2 Again, true quality or performance measurement is not an input or sum total of inputs, for example the sum total of information electronically sent and/or received between or beyond "meaningful EHR users", but again outcomes measured relative to

spending.

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Measuring and rewarding performance independent of spending also can and does produce perverse effects. These obviously need to be avoided. For example, in a May Health Affairs' article researchers found CMS paid 231 hospitals participating in the 2015 Medicare Hospital Value-Based Purchasing (HVBP) program a financial bonus for spending efficiency despite the fact their quality scores were "significantly worse" than medium-and high quality hospitals that also received bonuses.3 Not surprisingly, this meant there was little correlation between quality performance and spending. Similar results have been found in the Medicare Shared Savings or ACO program. In 2014, the most recent year for which data is available, CMS paid bonuses or shared savings to 86 MSSP ACOs despite the fact these ACOs had a mean quality score that was worse than the worst financially performing 67 ACOs, or those that exceeded their negative Minimum Loss Ratio.4 Despite better quality none of these 67 ACOs received a financial bonus. Related research has shown similar results. For example, RANDS's Cheryl Damberg has shown hospital CAHPS scores have little relationship to efficiency.5

There are several opportunities to incorporate value in HIT interoperability measurement. For example, beyond the annual CMS call for measures, MACRA funds $15 million annually between 2015 and 2019 to identify gaps in performance measures. The ONC could work toward recommending ACI measures or MIPS Clinical Practice Improvement Activities (CPIA) measures that calculate or correlate a specific patient outcome with an investment made in HIT interoperability or interoperable use. For example, more timely diagnosis and treatment of a chronic condition exacerbation, for example COPD, via electronic monitoring or other HIT-driven care coordination. In addition, the ONC could work to correlate ACI measures with MIPS quality measurement and resource use. As currently proposed CMS will score each of these MIPS components independently. Failing to measure to what extent interoperability or interoperable use correlates with a quality outcome measure or efficient resource use is a lost opportunity.

The foremost or ultimate goal of measuring interoperability or interoperable use ought to be achieving optimum outcome value or value improvement. Absent this efforts to measure performance improvement will remain "off the rails." As Michael Porter noted earlier in 2010, "cost reduction without regard to outcomes achieved is dangerous and self-defeating." This leads to, he said, false savings or "ill-advised cost containment" that results in "micromanagement of physician practices which imposes significant costs of its own."6 In his comments at a Health Affairs' May 12th value-based payment meeting, the Commonwealth Foundation's David Blumenthal recognized the importance of choosing and prioritizing measures that drive value. This was necessary not only because of inherent worth but also because, he argued, the goal of improving value is necessary to gain the confidence and cooperation of providers, payers and other key health reform stakeholders.7 Unless or until performance measurement actually measures value, clinicians of all stripes will find or continue to find, rightly so, quality measurement, collection and reporting largely onerous, futile and costly.8 If Medicare and commercial plans alike intend to migrate payment from volume to

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value, they need to begin to actually measure value, or here the contribution interoperability or interoperable use makes toward outcomes achieved relative to spending. In addition, the ONC cannot reasonably expect the HIT industry to produce products and services that "improve patient outcomes" if the office is unwilling to measure the value their products produce.

Current and Other Data Sources or Measuring Widespread Exchange of Health Information
Concerning ONC's interest in identifying data sources or the fact "currently available data sources might not be sufficient to fully measure and determine whether the goal of widespread exchange of health information through interoperable certified EHR technology has been achieved." The RFI also states the ONC is "requesting feedback on additional national data sources which my able available for this purpose." The AMGA would welcome an opportunity to discuss with the ONC making its membership available to better measure the value of interoperable EHR technology.

Thank you for your consideration of our comments. AMGA would be happy to discuss these further. Please contact David Introcaso, Ph.D., Senior Director, Regulatory and Public Policy at 703.838.0033, extension 335, or via dintrocaso@amga.org, with any questions.

Sincerely,

Donald W. Fisher, Ph.D.
President and CEO

NOTES

1. Michael E. Porter, "Standardizing Patient Outcomes Measurement," The New England Journal of Medicine (February 11, 2016): 504-506. At: http://www.nejm.org/doi/full/10.1056/NEJMp1511701.
2. MedPAC, "Report to Congress: Medicare and the Health Care Delivery System," (June 2014): 41. At: http://www.medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0.
3. Anup Das, et al. "Adding a Spending Metric to Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals," Health Affairs (May 2016): 898-906.
4. MSSP 2014 results are at: https://data.cms.gov/Public-Use-Files/2014-Shared-Savings-Program-SSP-Accountable-Care-O/888h-akbg.
5. Cheryl Damberg, "Charting a Path Forward: Opportunities to Strengthen Hospital Value-Based Purchasing," at: http://www.healthaffairs.org/events/2016_05_12_value_based_payment/media/slides.pdf.
6. Michael E. Porter, "What Is Value In Health Care?" The New England Journal of Medicine (December 23, 2010): 2477-2481. At: http://www.nejm.org/doi/full/10.1056/NEJMp1011024.
7. David Blumenthal's comments are at: http://www.healthaffairs.org/events/2016_05_12_value_based_payment/.

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8. Lawrence P. Casalino, et al., "US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures," Health Affairs (March 2016): 401-406 Report Quality Measures," Health Affairs (March 2016): 401-406. At: http://content.healthaffairs.org/content/35/3/401.abstract.