



June 3, 2016

Office of the National Coordinator for Health Information Technology  
Department of Health and Human Services  
[www.regulations.gov](http://www.regulations.gov)

Thank you for the opportunity to provide feedback on ONC's Request for Information Regarding Assessing Interoperability for the Medicare Access & CHIP Reauthorization Act (MACRA). The National Committee for Quality Assurance (NCQA) strongly supports the goal of achieving interoperability to facilitate coordinated care that improves patient outcomes. We are particularly encouraged to see an emphasis not only on the electronic exchange of information but on the subsequent use of exchanged information to support patient care.

However, we do not support using survey-based assessments to evaluate progress on interoperability. Surveys are subject to bias and gaming, do not capture all provider types, and do not offer valid measures of interoperability or actionable feedback on why data exchange is not occurring. This self-reported option is merely attestation and could undermine the broader goal of ensuring that health care providers are actually exchanging and utilizing electronic data to coordinate and improve patient care.

Instead of relying on surveys, ONC should explore whether other data sources, such as the EHR Incentive Program, registries, Health Information Exchanges, performance data from other programs, fee-for-service claims, and even direct feedback from HIT vendors might help. MIPS reporting will also offer substantial data for assessing progress on interoperability once it begins. ONC should examine whether any of these or other data sources might help provide a more accurate picture of interoperable exchange and use of information among providers."

You also should not limit measurement of interoperability to use of Certified EHR Technology (CEHRT), which is far too narrow. Although it is critical that quality measurement reporting systems be certified to ensure accuracy and validity, there are many other non-certified data sources from which providers can receive important information about their patients' health. Telehealth apps, registries, and even non-health care settings such as social services can contribute to rich patient data sets and should be included when measuring providers' exchange and use of information.

Regulatory schemes often set up firewalls against information sharing and subsequently impede care coordination efforts. There is also wide variation in how HIPAA is interpreted by states, plans, and other care entities. Such regulatory schemes and wide variations in the interpretation of HIPAA lead to significant barriers to information exchange. Behavioral health care providers in particular may be subject to privacy concerns, even when sharing patient information within a single clinical system. ONC must address these concerns before we can truly achieve widespread interoperability.

Measurement of interoperability should be broad enough in scope to capture data on populations across the entire care continuum, including behavioral health and long-term care providers. Although these providers may not be “meaningful EHR users,” they contribute to overall patient outcomes and should be accountable for sharing information in order to support better care for patients.

Consistent with MACRA’s goal of greater alignment across public and private payers, measurement of interoperability should include the degree to which providers are exchanging and using electronic patient information for individuals covered by non-Medicare payers.

This ‘other payer’ principle was applied in the MACRA proposed rule for determining thresholds for Qualified Participants (QPs) in Other Payer Advanced Alternative Payment Models (APMs), and should be used again here.

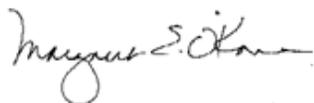
Providers participating in the Merit-Based Incentive Payment System (MIPS) and Advanced APMs should be measured according to standards consistent with expectations under MACRA. The activities detailed in the Advancing Care Information (ACI) category of MIPS should be the performance floor for all providers, regardless of payment track. Measurement of MIPS providers should be based on these activities. Measurement of QPs in Advanced APMs should be significantly more robust. For example, rather than providing the ACI measure “Clinical Data Registry Reporting” as an optional activity, QPs could be measured on their level of participation in those registries. QPs could also be measured on their use of sophisticated analytic systems to implement data-driven interventions, such as providing comprehensive post-discharge care plans for patients that are at higher risk for readmission.

Priority measures of interoperability, in addition to the activities listed in the RFI, should focus on the areas of care delivery where we know gaps exist. Referral and case management, discharge planning, and care coordination are examples where systems often fail to communicate patient information across settings. ONC should ensure that the structure and process measures used to assess interoperability directly support improved performance in these gap areas and therefore contribute to better patient outcomes. These gap areas also could identify other providers who need to participate in data exchange in order to adequately measure interoperability for these priority measures.

Finally, consistent with the CEHRT adoption goals set by the MACRA proposed rule, ONC should define “widespread” electronic information exchange and use as 75%.

Thank you again for the opportunity to provide feedback on this issue. If you have any questions, please reach out to Joe Castiglione, Federal Affairs, at [castiglione@ncqa.org](mailto:castiglione@ncqa.org) or (202) 955-1725.

Sincerely,

A handwritten signature in black ink, appearing to read "Margaret O'Kane". The signature is fluid and cursive, with a large loop at the end.

Margaret O’Kane  
President