



Physicians Caring for Texans

May 15, 2013

Senator Lamar Alexander
Senator Tom Coburn
Senator Pat Roberts
Senator Richard Burr
Senator Mike Enzi
Senator John Thune
United States Senate
Washington, DC 20510

Via email: HealthIT_CommentPeriod@thune.senate.gov

Re: Reboot: Re-examining the strategies needed to successfully adopt health IT

Dear Senators:

The Texas Medical Association (TMA) is a private, voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, our maxim continues in the same direction: "Physicians Caring for Texans." TMA's diverse physician members practice in all fields of medical specialization.

On behalf of our more than 47,000 member physicians, TMA appreciates this opportunity to offer feedback on federal progress promoting health information technology adoption and standards. TMA recognizes the responsibility you have to evaluate the return on taxpayer investment in health IT and the programs funded by the federal government.

Interoperability

TMA recognizes that before interoperability can happen, physicians and other providers of care must first move from paper to electronic record keeping. The Health Information Technology for Economic and Clinical Health (HITECH) Act provided a much-needed incentive program to encourage adoption of electronic health records (EHRs). In 2005 only 25 percent of Texas physicians reporting using an EHR. TMA's 2012 survey revealed the number of physicians using an EHR swelled to 60 percent, with another 22 percent planning to adopt in the next two years. This is significant growth in a short time. But growth alone is not a complete measure of

success. Electronic exchange of patient information has not made adequate progress for a variety of reasons.

TMA believes the meaningful use goals should carefully align with market ability so systems and processes are not hastily developed, as that may lead to unintended consequences. Texas has received \$28 million through HITECH incentives to develop health information exchange (HIE) infrastructure, yet only a few funded HIEs have implemented the ability to query and effectively exchange patient information. The effectiveness of this exchange has not been validated, thus there are many challenges in front of us.

In our experience, interoperability and HIE is still extremely difficult to accomplish despite several years of meaningful use. We have found that each vendor requires individual configuration and that vendors and clinicians often do not work together effectively to implement clinically-meaningful data exchange. TMA strongly believes that, to truly achieve interoperability, CMS and ONC need to focus on a comprehensive set of connectivity tests that EHR and HIE vendors need to pass in order to certify for meaningful use.

TMA feels strongly that physicians should be able to send *any* piece of a patient's health data from one EHR to any other electronic database in a form that can be sent on to other databases. Currently this is not the direction of the meaningful use program. This could be done through Direct, HIEs and other data transfer mechanisms. To accomplish this level of data exchange as quickly as possible, CMS and ONC should require EHR vendors to tag *all* EHR data elements with standardized XML. Vendors also would need to be able to receive and process data feeds using this standardized XML, and store it in their native tables. This process already is used for the CCD/CCR, but on a limited scale.

Market competition, or resistance among competing entities, is not the main impediment to HIE. Rather, the failure thus far to develop and promote a common data standard format for HIT, and the accompanying standard format for the transfer of health information (as well as a practical and definitive national provider identifier system and master patient indexing system), seems to be one of the biggest obstacles to widespread HIE across disparate organizations. Additionally, we see significant liability issues related to HIPAA, CLIA and other laws that inhibit data exchange.

We also see significant variability in the interpretation of laws regarding so-called “sensitive” data. Some HIEs will display HIV results, for example, while others will not. This creates a very large patient safety problem that is not being addressed adequately.

Finally, we also believe that certain types of patient-level data, such as a patient’s problems, simply cannot be made meaningfully interoperable using current technology and processes. This is not being discussed or addressed at a national level to the best of our knowledge.

Costs

In the paper environment it is easy for physicians to undercode for services provided as they often worry that their documentation won’t support the higher code. EHRs allow physicians to better document the care provided and thus bill at a higher level. This is not up-coding, but rather it is *appropriate* coding. Appropriate physician use of EHRs should not be targeted as contributors to the higher cost of health care. Once interoperability of systems is ubiquitous, it

will be easier to share patient information which will prevent duplicative testing and drive preventive services. Achieving savings in health care takes time and TMA encourages you to give it the necessary time.

Oversight

CMS has targeted auditing 5 percent of physicians who received meaningful use incentives. Some of the audits are random while others are based on a complex algorithm that CMS will not reveal. It sometimes is not even possible to provide some of the documentation required by the auditors. For example, auditors are asking physicians to provide a sample patient list with the EHR logo on the report. As part of the certification process vendors were not required to add logos to reports generated by the EHR. While TMA fully understands the need for program oversight, audit requirements should align with system capabilities.

Some additional oversight of the EHR vendors would be welcome. Some EHR vendors used tactics to persuade physicians to use their product, then once the contract is signed, customer service became practically nonexistent. TMA has evidence that some physicians cannot easily get their data when switching vendors. Vendors should not be allowed to prevent access to patient data. Physicians are required by state and federal law to provide their patients with a proper medical record when requested. EHR vendors should not be allowed to interfere with this process.

CMS and ONC should consider that when physicians are forced to transition to another EHR, the data migration is very expensive and is cost-prohibitive for small practices. For example, a physician in Texas was recently forced to change EHRs because a major vendor was sunsetting the product this physician had purchased only 9 months before. The new product the vendor recommended (a different version of their offerings) cost twice as much as the product initially purchased. Because of the price difference, the physician shopped around and decided to switch to another company. The cost for the physician to migrate only 9 months of patient data was \$12,000. One possible solution to this problem would be to require vendors to tag key data element that would typically be moved in an EMR transition with standardized XML. Vendors would also need to be able to receive and process data feeds with this standardized XML, storing it in their native tables. This process is used for the CCD/CCR but on a limited scale. This process would also assist with transfers of clinical data to HIEs (as described above).

Patient Privacy and Involvement

One major concern that physicians have is that they are responsible for the actions of HIEs in protected health information (PHI) breaches. As they realize this, their desire to share information declines, as there is a liability that they cannot control. TMA believes strongly that legislation to protect physicians from the errors of HIEs regarding PHI breaches is urgently needed.

Part of meaningful use criteria requires patient engagement. TMA believes patients should take a greater role in their own health decisions, and encourages strong patient-physician relationships. But TMA also believes this should be a patient-level decision, not a mandate on physicians. Stage two of meaningful use has two measures that require patient action. TMA strongly opposes physicians being measured, incentivized, or penalized based on the actions of patients that are beyond the physician's control and, therefore, recommends the elimination of

those two measures. TMA believes the goal is social engineering and there is no evidence to show that improved outcomes will be the result of physicians' actions to change patients' behavior in the proposed manner. Without such evidence, it is not reasonable for CMS to base financial incentives or penalties on a physician's ability to socially engineer this particular patient behavior. Many physicians treat elderly and indigent patient populations and it is not reasonable to expect these patient to have access to a computer and the internet to download or transmit information, much less the desire to do so. If CMS desires patients to behave a certain way, the incentives should be for those patients. It should not be required of physicians.

Sustainability

TMA respectfully requests that the physician EHR incentive program not be interrupted so that physicians may continue to receive the incentives they were promised at the onset of the program. For those who have made investments based on this program, it would seem fair to complete it.

That said, TMA is extremely concerned about the ability of physicians to accomplish all of the various programs that CMS has scheduled for the next few years. We are particularly concerned about ICD-10, which will require expensive implementation of a coding system that will be outdated in a short period of time. Implementation of ICD-10 is generating a huge disruption at exactly the same time that we are trying to achieve the interoperability that we all desire.

* * *

Thank you for the opportunity to provide feedback on federal progress promoting health information technology adoption and standards. Should you have any additional questions or need any further information, please do not hesitate to contact us, Shannon Vogel, 512-370-1411, or Jeff Gdula, 512-370-1344, Texas Medical Association.

Sincerely,

A handwritten signature in black ink, reading "Joseph H. Schneider". The signature is fluid and cursive, with the first name "Joseph" and last name "Schneider" clearly legible.

Joseph H. Schneider, MD, MBA
Chair, *ad hoc* Committee on Health Information Technology