



Physicians Caring for Texans

April 22, 2013

Farzad Mostashari, MD, ScM  
Office of the National Coordinator for Health Information Technology  
Hubert H. Humphrey Building; Suite 729D  
200 Independence Ave. SW  
Washington, DC 20201

RE: RFI -- Advancing Interoperability and Health Information Exchange

Dear Dr. Mostashari,

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 medicine.

On behalf of our more than 47,000 member physicians, the TMA appreciates this opportunity to comment on the above referenced request for information on advancing interoperability and health information exchange (HIE).

Should you have any additional questions or need any further information, please do not hesitate to contact me directly or contact Shannon Vogel at TMA at 512-370-1411.

Sincerely,

A handwritten signature in black ink that reads "Joseph H. Schneider". The signature is written in a cursive style with a large, prominent "J" and "S".

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

## **Overarching comments:**

In our experience, Interoperability and Health Information Exchange (HIE) are still extremely difficult to accomplish despite several years of Meaningful Use. We have found that each vendor requires individual configuration and vendors and clinicians are not working together to implement clinically-meaningful data exchange. To truly achieve Interoperability and HIE CMS and ONC need to focus on a comprehensive set of connectivity tests that EHR vendors need to pass 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. Recipient databases should include other EHRs, PHRs, thumb drives, DVDs, and other electronic media, with the resulting data further transferrable to any other certified EHR. This can be made possible 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 the biggest obstacle in widespread HIE across disparate organizations. Additionally, we see significant liability issues related to HIPAA that will inhibit data exchange. Finally, we also believe that certain types of patient-level data, such as a patient's problems, cannot be made meaningfully interoperable using current technology and processes.

### **Q1. What changes in payment policy would have the most impact on the electronic exchange of health information, particularly among those organizations that are market competitors?**

A1. Any changes in payment policy must be carefully evaluated for their impact on quality and the economics of physician practices and small hospitals. The Meaningful Use Program is an example of what not to do – i.e., an incredibly detailed set of requirements that are expensive to implement and have very limited flexibility.

Paying physicians and hospitals an annual incentive for exchange of XML-tagged data (the CCD and its successor, as described above) would help encourage electronic exchange. Penalties for failure to exchange should not be implemented, as the gains associated with exchange do not accrue to hospitals or physicians.

**Q2. Which of the following programs are having the greatest impact on encouraging electronic health information exchange: Hospital readmission payment adjustments, value-based purchasing, bundled payments, ACOs, Medicare Advantage, Medicare and Medicaid EHR Incentive Programs (Meaningful Use), or medical/health homes? Are there any aspects of the design or implementation of these programs that are limiting their potential impact on encouraging care coordination and quality improvement across settings of care and among organizations that are market competitors?**

Q2. TMA believes strongly that HIPAA and the liabilities associated with it will prove to be a significant barrier to health information exchange. We are concerned that physicians may be unwilling to exchange information in situations where they may be liable for the use of the information after they send it to an HIE.

CLIA also has proven to be a barrier to health information exchange, as laboratories are claiming that they cannot release information to anyone except the ordering physician. While this is true in a few states, it is not in others.

**Q5. How could CMS and states use existing authorities to better support electronic and interoperable HIE among Medicare and Medicaid providers, including post-acute, long-term care, and behavioral health providers?**

A5: A single common data standard format for HIT and HIE would enable entities such as post-acute, long-term care, and behavioral health to invest definitively in data systems to support their operations. As it now stands, the lack of HIE is the main determinant in the lack of real-life utility of such systems in the daily business and operations of such facilities. For behavioral health providers in particular, the legal constraints surrounding the exchange of sensitive behavioral health data impedes HIE from a practical standpoint. However, once a common data format and transfer protocol emerges, it will be possible to classify certain data subsets in accordance with levels of security and privacy; finally allowing such facilities and providers of behavioral health to place themselves on the common grid without material fear of inadvertent breaches. Without such a standard, however, meaningful HIE may never occur in such facilities.

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. 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, storing it in their native tables. This process is already used for the CCD/CCR, but on a limited scale.

**Q9. What CMS and ONC policies and programs would most impact patient access and use of their electronic health information in the management of their care and health? How should CMS and ONC develop, refine and/or implement policies and program to maximize beneficiary access to their health information and engagement in their care? What specific**

## **HHS policy changes would significantly increase standards based electronic exchange of laboratory results?**

A9: A key missing element in the elusive goal of widespread HIE activity of useful clinical data that follows the patient across settings in real time is the lack of a common data standard format for HIT, and the accompanying standard format for the transfer of HIT (as well as a practical and definitive national provider identifier system and master patient indexing system). CMS and ONC should definitively convene an ongoing consortium of medical specialty societies and HIT stakeholders and settle on a common standard for both, as well as a set of consistent rules for appropriate legal and security safeguards which are required for HIE activities across covered entities. After such a standard emerges, both patients and covered entities/providers will be able to exchange structured data in real time, using either CDR or federated models of transfer and storage. The common standards will enable data to be parsed and tagged/classified, so as to prevent duplication, enable privacy settings for certain data, and enable diversity in the usability and presentation of the data in the specific user cases. Clearly, one common means of data management will resemble the iconic 'Blue Button' single download feature of all pertinent data for a single patient into one authorized repository, such that a patient's data can be updated into whichever system is being updated (similar to how a person can 'refresh' the website they are viewing over a period of time). However, none of this will be possible unless and until a common data standard for both documentation and transfer is adopted.

As for laboratory results which the RFI specifically queries, this provides the most basic use case of the above. Once a common data standard and transfer standard is adopted, laboratory data would easily migrate between covered entities.