TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

February 20, 2018

Don Rucker, MD
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St. SW
Floor 7
Washington, DC 20201

RE: Comments on Draft Trusted Exchange Framework; Submit to exchangeframework@hhs.gov

Dear Dr. Rucker,

On behalf of the Texas Medical Association (TMA) and our more than 51,000 physician and medical student members, we thank you for the opportunity to comment on the Draft Trusted Exchange Framework.

Overarching Comments

TMA recognizes the challenges of exchanging health information and that a one-size-fits-all approach does not work in health care. Over the years, since the HITECH Act of 2009, TMA has submitted numerous comments suggesting ways that health information exchange could be improved. We do believe that the Framework has potential to move forward the needed policy levers to improve how information is exchanged among disparate health information systems.

TMA remains concerned about interface connection and maintenance fees that electronic health record (EHR) vendors charge to physicians. For many years, TMA has advocated for universal use of extensible markup language (XML) or a similar standard (e.g., FHIR) as a way of exchanging meaningful health data, as is used in accounting and other industries. Universal common encoding of *all* data elements could permit disparate systems to share and consume information much more easily. Information consumed by a receiving EHR could be placed correctly within the system to give it meaning and make it useful.

A simple example that is not currently possible is transmitting pacemaker information and settings via discrete data between a hospital and the follow-up physician's EHR, even in some cases if they use the same vendor. Standardized coding of data elements would make this easy and cheap. This would allow the information in the receiving EHR to be searchable, extracted for

reports (such as medication or device recalls), and available for clinical decision support. A more complex example of the benefits of standard tagging in an EHR database is where a physician desires to change EHRs. If the receiving EHR has the same functionality as the sending EHR, standard tagging would make it possible to move from one EHR to another almost instantaneously and at little to no cost.

It is time that the Centers for Medicare & Medicaid Services (CMS), the Office of the National Coordinator for HIT (ONC), and the National Institute of Standards and Technology (NIST) push for such a standard to make the sharing of data safer, faster, and cheaper.

Comments Specific to the Draft Trusted Exchange Framework

Part A

Overview (pg. 3)
TMA agrees in part with the vision that ONC has set, but recommends an expansion that should include:

- ***Promotes high standards for data privacy and security at all points of electronic health information storage and exchange. The privacy and security of electronic health information will always be considered a higher priority than shared exchange.***
- ***Achieves such value that all stakeholders feel motivated to participate.***

How Will It Work? (pg. 9)
Is there a reason that ONC or some other existing agency cannot perform the functions defined for the recognized coordinating entity (RCE)? It seems the RCE could actually impede progress and stifle stakeholders' ability to exchange information in ways that may be working already. ONC, CMS, or even NIST would be better suited to operationalize a national exchange effort. Another bureaucratic layer adds cost and potentially hinders progress. We are concerned that the exclusive role that the RCE will be given will stifle innovation at a time when innovation is very much needed. Similarly, we are concerned that the RCE will be so consumed with basic tasks that it will be hard-pressed to support specialized needs such as adolescent privacy.

TMA agrees with ONC that a single on-ramp is useful for many cases, but not all, and appreciates that point-to-point connections can be created to serve the needs of the organization, community, and ultimately the patient. TMA is concerned that ONC may unintentionally create barriers when restricting one-off connections that do not conform with the Framework. Perhaps exceptions could be considered if the non-conforming connection brings value to users.

TMA agrees that a usable online directory of Trusted Exchange Framework and Common Agreement participants should be available. This is a major limitation of the DIRECT exchange system.

Comment Process (pg. 11)
Identity proofing could follow existing e-prescribing of controlled substances (EPCS) standards as set by the DEA. If physicians can use the same identity-proofing requirements, it can increase

compliance by reducing the number of token, fobs, and passwords needed for access controls.

Principle 2. C. 5. (pg. 17)
TMA agrees that patients must easily be able to opt out of participation in the Qualified Health Information Network (QHIN) and have the ability to ensure that all data currently within the QHIN is removed. It should be noted on any future queries that said patient has opted out of the system. This informs physicians and other providers of the patient's status, and provides an opportunity to discuss the benefits of information sharing.

TMA agrees that patients should have easy access to information about who has seen, accessed, or used their health information.

Principle 3. (pg. 17)
TMA strongly objects to the punitive approach set forth in Principle 3, which discusses cooperation and non-discrimination. When business competitors see value in a shared exchange of electronic health information, they will feel motivated to participate. When physicians and their patients see value in the exchange of their electronic health information, they will feel motivated to participate. Rather than telling stakeholders what they should not do – "they should not treat electronic health information as an asset that they can restrict in order to gain competitive advantage" -- instead, positively state that the trusted framework intends to achieve such value that all stakeholders will eventually be incentivized to fully participate in order to gain their part of the value.

Along this same vein, TMA strongly recommends that the data blocking attestation requirement for MIPS be removed until secure, safe and effective exchange of information is available nationally and value is achieved. ONC and CMS should cease the punitive treatment of physicians who do not participate in health information exchange systems, many of which may be fraught with cybersecurity risk, high costs, and low value for stakeholders.

Principle 6. A. (pg. 21)
TMA cautions ONC to take the crawl, walk, run approach when it comes to the QHINs providing the ability for participants to both pull and push population-level records in a single transaction. This may increase the risk of mass data breaches or unauthorized meta-data analysis. ONC should focus on the ability of disparate organizations to exchange discrete data efficiently before advancing to mass-data exchange. TMA understands that physicians participating in various quality programs may desire submitting patient-level data and reports to public and private payers via the QHINs to desired registries. The privacy and security of electronic health information should always be considered a higher priority than shared exchange.

Part B

Requirements of Qualified HINS 2. 1 (pg. 30)

Regarding no limits of electronic health information aggregation, TMA is concerned that patients may not be able to revoke their data in this scenario should the patient choose to opt out of the QHIN.

We appreciate the opportunity to comment. Should you have any questions, do not hesitate to contact Shannon Vogel at TMA by calling (512) 370-1411 or emailing shannon.vogel@texmed.org.

Sincerely,

Matthew Murray, MD
Chair, ad hoc Committee on Health Information Technology