TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

January 28, 2019

Don Rucker, MD
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Mary E. Switzer Building, Mail Stop: 7033A
330 C Street SW
Washington, DC 20201

RE: Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.

Submitted via: www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs

Dear Dr. Rucker:

On behalf of the Texas Medical Association (TMA) and our almost 53,000 physician and medical student members, we appreciate the opportunity to provide feedback on the draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.*

TMA's long-time electronic health record (EHR) policy has stated that health information technology (HIT) should support physician workflow, increase practice efficiency, be safe for patients, and enhance the quality of care.

TMA appreciates the Office of the National Coordinator's (ONC's) attempt to provide strategies reducing physician burden in the following areas:

1. Clinical documentation,
2. Health IT usability and the user experience,
3. EHR reporting, and
4. Public health reporting.

Comments for each of the four areas are below.

Clinical Documentation

TMA agrees that clinical documentation is a large part of EHR-related burden. Referencing its 2019 Physician Fee Schedule proposal, the Centers for Medicare & Medicaid Services stated a primary goal of reducing administrative burden so physicians can focus on patient care. For outpatient office visits, the agency proposes the choice of medical decisionmaking and time-based documentation in addition to the 1995 or 1997 framework to document the appropriate level of evaluation and management (E&M). The proposed simplified E&M documentation requirements were designed to refocus physician attention on medical decisionmaking and what is needed for appropriate patient care. Physicians would no longer focus on documenting services to comply with guidelines under the threat of arbitrary audits.

We agree that the current requirements for visit codes stress meaningless "box checking," and we strongly support your proposal to leave the extent of history and physical documentation to physician discretion. We oppose the use of counting methodologies or numeric formulas in medical record documentation.

While ONC's report does not discuss flattening payment for E&M visits, CMS did recently propose paying one fee for level 1 visits and a different, flat fee for visit levels 2-5. CMS erroneously assumed that reducing one of many overly burdensome administrative requirements necessitates a significant reduction in physician payment. Eliminating the payment differential for the visit levels will penalize physicians who care for complex or complicated patients including those with disabilities and those with serious or terminal illnesses.

TMA advocates for physician payments to be accurate, fair, and adequate. While TMA applauds reductions in physician burden, we oppose any reduction in payments as that would negate desired improvements to patient care or reduction in physician "burnout," which are the real goals of burden reduction.

Note that any substantial changes to coding or documentation rules will **increase burdens**, as they will generate significant costs and administrative burdens for physician practices, including the costs for software updates, revisions of internal and external reports, and staff and physician training. Additionally, software vendors, billing companies, and others who serve physician practices will need lead time to revise their products and processes. Therefore, we urge that any rule change provide for adequate transition timelines.

TMA agrees with the strategy that health IT should be leveraged to standardize data and processes around ordering services and related prior authorization processes. ONC should note that the burdens related to orders or prior authorization often have nothing to do with clinical documentation. A recent example cited to TMA is about the challenges of pediatricians ordering vaccines, where the order choices ranged from extremely simple to ridiculously complex.

The following is TMA's policy on prior authorization, which may help ONC hone its strategy:

> *Authorizations Initiated by Third-Party Payers, Benefit Managers, and Utilization Review Entities:* The Texas Medical Association supports policy and legislation

that (1) third-party payers, benefit managers, and utilization review entities may not implement prior authorization mechanisms unless these payers compensate physician practices for work required independent of any payment for patient care; specifically, medical practices must be compensated for the burden of added staff and resources required to navigate payer-initiated prior authorizations for medications, studies, or procedures; (2) third-party payers, benefit managers, and utilization review entities should disclose all prior authorization requirements and restrictions on their websites in both the subscriber section and the physician section with neither location requiring a log-in or password; (3) third-party payers, benefit managers and utilization review entities should confirm patient eligibility, payment determinations, medical policies and subscriber specific exclusions as part of the prior authorization process; and (4) third-party payers, benefit managers, and utilization review entities should make detailed statistics regarding prior authorization approval and denial rates available on their website.

Health IT Usability and the User Experience

TMA has recognized for years that the greatest impediment to the effective use of health information technology is the poor usability of EHRs. EHRs must be designed to support physician workflow while increasing office efficiency, and more importantly, patient safety. The requirements for payment and incentive programs, such as the Merit-Based Incentive Payment System (MIPS), generally have decreased the usability of the EHR, which equates to less time focused on the patient.

TMA's 2018 HIT survey indicates 85 percent of Texas physicians now use an EHR in their practice, and of those, 36 percent are either very or somewhat dissatisfied with their EHR. ONC hopefully agrees that 36-percent dissatisfaction indicates poor EHR performance. ONC should support physicians in efforts to improve EHR functionality by working closely with professional organizations and the vendor community on product improvements and standardization of certain functions.

To start improving this situation, TMA recommends that ONC support:

- Universal adoption of a nationally standardized "green" (or other color) button that clinicians would use to submit EMR glitches or errors to the vendor and possibly to an aggregator of health IT patient safety issues, such as a patient safety organization. Ideally the green button would capture data such as a screen shot, computer diagnostics, keystroke history, the time and location, user information, and other key elements, and allow the user to provide a comment describing the problem. This enables quick reporting of problems at the time of occurrence and within the physician's workflow. Having this capability standardized across all platforms would minimize the burden of using this tool and should lead to improvements.

- Standardized clinical concepts, developed by the leadership of professional medical organizations. This is a huge task. The first could be standardization of allergy and intolerance representations within EHRs. Currently there are many often-incompatible ways of representing these concepts. Incompatible representation is a patient safety issue as we make data interoperable, and so this undertaking should be an extremely high priority. This same approach could be used for

medications, problems, diagnoses, equipment, supplies, vaccinations, newborn screening reporting, demographics, and other concepts. Prioritization should occur nationally so that every two years an additional concept is standardized.

- Use of assistive technology to extract key clinical problems and other information to populate the problem lists, diagnoses lists, equipment lists, supply lists, and other applicable areas. While the information contained in the record is the same across all specialties, the visualization should be customizable based on each specialty's clinical needs or subsequent user's role. This approach reduces the burden of information overload.

- The ability to transition from one EHR vendor to another and maintain the full electronic patient record. TMA continues to hear from physicians who are charged exorbitant fees from vendors to get their own patients' data transferred. Many physicians who are dissatisfied with their EHR are unable to switch to another product due to data portability issues and cost. TMA believes that, like in other marketplaces, usability would skyrocket if physicians could switch EHRs easily by moving their data from one product to another seamlessly. To this end, for years, TMA has advocated for *universal* (i.e., all EHR data) use of extensible markup language (XML) or a similar standard (e.g., FHIR) as a way of exchanging health data, as is used in accounting and other industries. Universal common encoding of all data elements would allow physicians to change their EHRs quickly with very little cost. Data consumed by a receiving EHR could be placed correctly within the new system to give it meaning and make it immediately useful. It is important that physicians have the ability to export and import tagged patient data from one EHR to another, especially when changing vendors. *Unless ONC requires vendors to tag all data fields, allowing complete mapping between disparate systems, this problem will continue to exist.*

- Standardized orders/clinical decision support tools developed by medical professional organizations that allow physicians to treat all patients equally and appropriately, regardless of diagnosis (e.g., Down syndrome) or demographics (e.g., sexual/gender identity). These could be delivered through FHIR, CDS Hooks, or other specifications.

- Standardization and easy production of forms such as workers' compensation authorization, death certificates, disability forms, work excuses, and school physicals. While this is challenging, programming or manually producing unique reports is very burdensome.

- The use of personal health records to reduce physician/office burden in maintaining accurate patient demographic and clinical information instead of having to query patients and update records at each encounter.

- The inclusion of changes such as the above *without additional costs to users*.

EHR Reporting

First of all, TMA recommends that CMS stop with program name changing. CMS went from Meaningful Use to Advancing Care Information to Promoting Interoperability. The portal for reporting

has gone from the Enterprise Identify Management (EIDM) Account to the HCQIS Access Roles and Profile (HARP) System. While it may seem important to change the name because the underlying program is being modified, the name changing is a significant burden to physicians because it causes confusion within an already too-complex environment.

Second, as ONC and CMS contemplate simplifying reporting, be sure the simplification is applied to all CMS programs. As part of the simplification, EHR vendors should provide standardized reporting for all CMS programs. Data extraction for any report desired by the physician or others within the practice should not require a service request to the EHR vendor. This is a waste of time and resources.

Public Health Reporting

ONC should query all states for public health reporting requirements and seek ways to simplify and standardize this effort. EHR vendors should not have to build 50-plus types of interfaces for the various public health departments. As an example, in Texas:

- There is still no statewide syndromic surveillance reporting.
- Electronic case reporting is not available for ambulatory practices.
- Every practice/hospital organization has multiple unique electronic interfaces to a multitude of state departments, agencies, and programs.

These programs are pushed through the Promoting Interoperability program, yet the electronic reporting capabilities are still in infancy because of the lack of standardization. It is a huge burden for physician practices to untangle what's required. The uncoordinated and nonstandard approach to results reporting is a significant burden and a waste of time and resources.

TMA appreciates the opportunity to provide feedback on the draft strategy. 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,

Matt Murray

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Texas Medical Association