



Physicians Caring for Texans

June 3, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9115-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Posted to *Federal Register* 06-03-2019

RE: Proposed Rules | CMS-9115-P; Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-facilitated Exchanges and Health Care Providers.

Dear Administrator Verma:

On behalf of our nearly 53,000 physician and medical student members, the Texas Medical Association (TMA) thanks you for the opportunity to comment on the above-referenced proposed rules also known as Interoperability and Patient Access.

Overarching Comments

TMA appreciates the Centers for Medicare & Medicaid Services' (CMS') desire to improve interoperability and reduce clinician burden. While the proposed rules are well-intended, TMA cautions CMS to better anticipate the unintended consequences of proposed requirements as they relate to typical physician practices. In particular, we have concerns about risks of patient harm from some of the requirements and overly aggressive timelines. More importantly, we believe CMS should focus less on stopping information blocking and more on increasing the value of electronic protected health information (ePHI) exchange such that it becomes a business and clinical imperative to participate in such exchanges.

Also, while TMA agrees that CMS correctly places much responsibility on the payer community to provide information to patients, there is concern that payers, through coercive contracts, will place additional responsibility on network physicians. Any associated costs with implementing the proposals

should not fall to physicians, and CMS should prohibit payers from using these proposals to place additional contractual demands on physicians.

I. B. Overview

Comment: CMS has indicated that when a patient receives care from a new physician or provider, “a complete record of their health information should be readily available to that care provider, regardless of where or by who care was previously provided.” TMA agrees that this is an attractive concept, but it is not practical and would flood physicians with a clutter of meaningless data. “Note bloat” is already a major issue that frustrates physicians today. One emergency department (ED) physician, for example, commented that when a patient is transferred to his ED from another facility, he might find himself sifting through 50 pages of records printed from the referring facility’s electronic health record (EHR) for an ED visit lasts only two hours. The relevant data he needs is typically less than one page. As another example, requiring a patient’s APGAR scores from birth (checking a baby’s heart rate, muscle tone, and other signs) is likely helpful for the patient’s new pediatrician, but when that same patient is 70 years old those scores are meaningless and make it more difficult to find relevant information. In addition, the costs for storage, data processing, and other implications of making available a “complete record” are immense. These financial costs, along with the inundation of meaningless data onto the physician is unduly burdensome, especially those operating a small practice.

Recommendation: TMA recommends that CMS change this language to “a record of the patient’s relevant health information” rather than using the word “complete.”

I.E.1. Patient Identifier and Interoperability

Comment: CMS seeks comment on ways in which the Office of the National Coordinator for Health Information Technology (ONC) and CMS can continue to facilitate private-sector efforts on a workable and scalable patient-matching strategy so that the lack of a specific unique patient identifier does not impede the free flow of information. The entire discussion on patient matching ignores the concept of patient control over matching through a voluntary identifier or patient approval of match attempts. The impact of a false positive (inappropriate match) or a false negative (failure to match) can be reduced dramatically if the patient (or his or her surrogate) is required to confirm the match or if the patient agrees to the use of a voluntary universal identifier.

Recommendation: TMA encourages CMS to support efforts that use patient control and patient approval in addition to passive matching processes that do not involve the patient.

I.E.3. Information Blocking

Comment: TMA agrees that intentional information blocking should cease. TMA has received reports from Texas physicians having difficulty receiving medical records from hospitals when a patient presents to a specialist for follow-up care. This specialist may be unaffiliated with the hospital, but the information is necessary for continuity of care and reduction of duplicate services. For example, a gastroenterologist requested a record from a patient’s visit to the emergency department where the patient presented with epigastric pain. The patient had a CT scan of the abdomen during the hospital visit. Therefore, the specialist did not find it medically necessary to repeat the order. It took an inordinate amount of administrative work from the gastroenterologist’s office and more than a week to receive the record from the hospital.

Recommendation: TMA encourages CMS to keep working to stop information blocking, especially when it impedes patient care.

II.A.2. Privacy and Security Concerns in the Context of APIs

Comment: CMS' statement that "[w]e recognize that this is a complex landscape for patients, who we anticipate will want to exercise due diligence on their own behalf in reviewing the terms of service and other information about the applications they consider selecting" is misguided. The complexities of the terms of services created by application providers makes them nearly impossible for the average lay person to understand. Even with a strong business associate agreement in place, if a third-party breach occurs, physicians are harmed as the data contributor, and patient trust is diminished.

Recommendation: TMA recommends that CMS support industry efforts to develop standardized terms of service with strong privacy provisions. Application providers should be required to adhere to these privacy provisions, and patients should be able to rely on the provisions as acceptable.

II.B. Content and Vocabulary Standards

Comment: TMA agrees that a catalogue of content and vocabulary standards is critical for entities developing application programming interfaces (APIs) and providing information to patients.

II.C.1.b. API Technical Standard and Content and Vocabulary Standards

Comment: CMS states that "[e]ntities that would be required to implement an open API under this rulemaking would be free to upgrade to [a] newer version of the required standards, subject only to those limiting conditions noted here, and at any pace they wish. However, they must continue to support connectivity and make the same data available to applications that have been built to support only the HHS-adopted version(s) of the API standards." This is admirable, but at times it is necessary to separate from previous versions of standards. The inability to do this will stifle progress.

Recommendation: The rule needs to allow movement to a fully balloted standard even if that standard does not support a previously adopted version.

III.C.2.c.(4) Drug Benefit Data, Including Pharmacy Directory, and Formulary Data

Comment: TMA appreciates the data elements that should be included in the drug benefit data. One other element that would be helpful to patients is the cost information by pharmacy within a certain radius of the patient's ZIP code.

Recommendation: TMA recommends that drug benefit data include prescription cost by pharmacy and formulary data.

III.C.2.k. Information Sharing Between Payers and Providers Through APIs

Comment: TMA believes it is useful to place relevant patient information before physicians to assist them with decisionmaking at the point of care, especially in emergent situations when limited patient data is available. TMA supports the concept of sharing payer data with physicians and believes that local health information exchanges can assist with secure, trusted exchange of this data.

Recommendation: TMA recommends that CMS explore options for providing relevant data at the point of care to assist physician decisionmaking regarding the patient's care.

IV.B. Broad API Access to Provider Directory Data

Comment: It is helpful for physicians to have access to an accurate, up-to-date provider directory for the purpose of in-network referrals. To facilitate the secure, point-to-point exchange of patient information, the provider directory could include a physician's Direct address. The Direct protocol should be promoted and used as a standardized point-to-point format within all EHRs and data exchange networks. Currently, physicians can obtain multiple Direct addresses from various sources such as EHR

vendors, health information exchanges, and hospital networks. In some cases, physicians are auto-assigned a Direct address and may not even realize it exists. Furthermore, not all health information service providers are interconnected, thus limiting the reach a physician may have with a Direct address. For example, a physician may have a Direct address assigned from EHR vendor A, and that vendor is not connected to vendor B. That means a physician using vendor A cannot exchange data via Direct to a colleague using vendor B, which limits the utility of Direct. Physicians should have one Direct address that is interconnected with the health information service provider network nationally, thus removing the need for multiple addresses, and that reaches across disparate systems. Physicians could then adopt **one** address regardless of EHR vendor, HIE participation, or hospital privileges.

Recommendation: CMS should promote the use of Direct addresses and publish addresses within the payer's provider directory via APIs to facilitate the sharing of patient information within payer networks.

VIII.A. Information Blocking Background and Public Reporting

Comment: CMS proposes to publicly report information about an eligible clinician's negative attestation regarding information blocking under the Quality Payment Program on the Physician Compare website. Rather than spending time on reporting how an individual physician attested to a measure, CMS should focus on increasing the value of safe, private, and secure exchange of ePHI so that it becomes imperative for hospitals and physicians to participate in such exchange.

Recommendation: CMS should not publicly report information about an eligible clinician's attestation regarding information blocking. Such reporting does not promote quality, enhance patient care, or incentivize true adoption of ePHI exchange. CMS should instead focus on promoting the safe, private, and secure exchange of ePHI to increase its value such that it becomes a business and clinical imperative for hospitals and physicians to participate in ePHI exchange.

IX.B. Proposed Public Reporting of Missing Digital Contact Information

Comment: CMS proposes to publicly identify the names and National Provider Identifiers of clinicians who have not submitted digital contact information to the National Plan and Provider Enumeration System (NPPES). The right to practice privately as an individual physician is important. By identifying those who do not register with the NPPES, CMS effectively is denying this basic right for physicians who do not participate in any government program.

Recommendation: TMA strongly recommends that CMS restrict notification of failure to file with the NPPES solely to physicians, clinicians, and health care organizations that participate in programs such as Medicare, Medicaid, and the Children's Health Insurance Program. Insurers may make requirements similar to CMS, but if a physician is a member of no health plans – private or government – then he or she should not be identified as not registering with NPPES.

XII.C. Establish Principles for Promoting Interoperability in Innovative Model Tests

Comment: TMA agrees that it is vital for patients to have access to their own health information. Patient records should be portable so that patients can easily transfer information as needed to maintain a longitudinal record regardless of where they received care. Perhaps the long-term vision should be even higher – that all patients have a complete, portable electronic, standardized set of their own personal health information that they could give to any physician to plug into the practice's EHR, regardless of which EHR the physician uses. The potential value of this would make it a business and clinical imperative to exchange, rather than block, ePHI. Additionally, CMS should recognize that certain patient populations will not make the effort to access their own information electronically due to a

variety of limitations. This population should not be left behind, and considerations must be made to accommodate easy access to information for these patients.

Recommendation: TMA recommends that CMS consider all patient populations so that health information is accessible.

The *Annals of Family Medicine* published its [2017 study](#) citing that physicians spend more than half of their workday interacting with the EHR and performing administrative work. This is time taken away from direct patient care. CMS and ONC should use policy levers to release this burden on physicians by considering the impact of each new proposal. Physician time with the patient will result in higher quality care and better outcomes.

If you have questions about this recommendation, please do not hesitate to contact TMA staff by calling (512) 370-1411.

Sincerely,

A handwritten signature in black ink, appearing to read "David C. Fleeger". The signature is fluid and cursive, with the first name "David" being the most prominent part.

David C. Fleeger, MD
President
Texas Medical Association