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National Coordinator for Health Information Technology
Acting Assistant Secretary for Health U.S. Department of Health and Human Services

Dear Dr. DeSalvo,

Thank you for the opportunity for the undersigned members of the Health IT Policy Committee to submit comments on the report to the House and Senate Committees on Appropriations and the appropriate authorizing committees regarding the challenges and barriers to interoperability. Congress was specific in requesting that the report should cover the technical, operational and financial barriers to interoperability. This report represents the opinions of a number of HIT Policy Committee members, who would like to add to the recommendations of the report.

The request for a report reflects the great disappointment that despite 30 billion US dollars spent on EHR implementation and use, interoperability is for the majority of patients and providers still in the far future. Since interoperability was considered the panacea to controlling health care costs, the lack of interoperability has resulted in disillusionment and frustration on part of patients and providers alike.

As the report outlines, the barriers to interoperability are certainly multi-factorial. The report lists them as:

- Lack of universal adoption of **standards-based EHR systems**
- Changes in **operations workflow** among providers
- Complex challenges of **privacy and security** associated with widespread health information exchange
- Difficulty of establishing synchronous **collective action** among multiple participants
- Weak, and in some cases misaligned, **incentives**

The report outlines four recommendations which are overly focused on developing measures (2 out of 4) and don't build on the necessary steps mentioned earlier in the report to achieve accelerated interoperability: collective action and direct incentives. While the reliance on measures, certifications, and transparency contribute to the solution, they are insufficient to achieve interoperability at a rapid pace. Measures are good means of monitoring and rewarding interoperability but are not enough to fast track it.

While the report recognizes "Weak, and in some cases misaligned, **incentives**" as part of the problem, in our opinion there are no effective recommendations on how to handle this critical barrier.

There are numerous perverse incentives to block health information exchange. For example, while Hospital A may hold information on an MRI for a patient, who is currently being seen in Hospital B, neither institution under the current model has any incentive of sharing or receiving the information in the MRI. Hospital A would have to spend resources to make the information available to a potential competitor for free, while Hospital B's MRI scanner would be idle if the information is received and reviewed. As the report highlights current fee-for-service models are not offering sufficient incentives for Hospital B to request and review the information. A switch to value based performance measures would incentivize Hospital B to request the information to avoid penalties associated with repeating a procedure, it would ADD perverse incentives for hospital A since the information would aid the competing institution. Information blocking, which until now was mainly a problem associated with vendors trying to protect their market dominance and competitive advantage, would be leveraged at individual institutions. The report misses a recommendation that focuses on the problem of the cost and disincentives associated with an institution being asked to share information from its EHR system. While the payment incentives proposed in the report focus on the receiving and reviewing end of the exchange, the report neglects the sending part of the health information exchange.

The problem with the lack of incentives on the sending end has already been demonstrated very effectively. To send health information is costly and must be sustained. This is highlighted by the fact that despite the initial investment of millions of federal and private funds in HIE infrastructure, these HIEs suffer from a sustainability crisis. This crisis was caused because an appropriate policy environment is missing to support a business model for collective exchange. At this point it must be pointed out that Health Information Exchanges do not necessarily increase interoperability; interoperability increases the exchange of health information. Exchange requires vendors to open their systems to interface programmers thus reducing the burden placed on providers, hospitals, and consumers in determining what data can be shared (and integrated) and what cannot.

We propose that a new incentive model must be created to encourage health information exchange that focuses on incentives and barriers. This model must focus on the cost and effort spent by the sending party to any health information exchange. How such a model would look like and what the incentives (perhaps payments) would look like should be addressed by a multi-stakeholder work group. The effort of parties sending the required information to make health information exchange must be acknowledged and the efforts must be incentivized in order for the exchange to occur. It is our recommendation that a multi-stakeholder group work on developing an incentive model that reflects this reality.

In the meantime, we encourage CMS and ONC to consider one model that would be a low cost approach to provide incentives to organizations to participate in sending health information.

Consumer-mediated and -directed health information exchange

Taking a step back, we want to re-introduce a well-known form of exchange that is consumer directed that has been very successful and is used hundreds of millions times a day. This approach is also in line with ONC's Nationwide Interoperability Roadmap and one of its guiding principles related to empowering the individual. Thinking of money in accounts as information to be exchanged, consumers manage effectively to exchange large amounts of information to

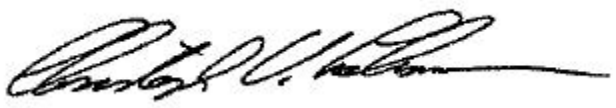
achieve bill payment, cash transfers, ATM withdraws, etc. Despite the fact that consumers use multiple banks and have a myriad of accounts, they manage to keep their financial information flowing across large networks. All consumers need to know is the bank they are working with (often in form of a hardware token like a debit card) and the account number associated with the financial information. There are incentives for organizations to participate because consumers select the organizations in part on the liquidity of their financial information to conduct their business. The number/density of of ATMs a bank operates plays into consumer decisions as well as the willingness of the bank to allow cash withdrawals from a location abroad when the consumer is traveling.

While the allegory of the use of computers in banking and health care has been overly stretched, in this case it may offer an incentive model that would be useful to stimulate health information exchange and may offer some solutions to the concerns related to privacy and security as well as the lack of a national patient identifier.

Providing consumers with a tool to aggregate all their "Health account" in one place (for example an online tool like Mint.Com or a hardware token) would allow a consumer being seen in Hospital B to direct his/her treating team to request information from hospital A with his/her identifiers (Medical Record Number for Hospital A). Not only would this constitute a direct request from the consumer and would aid with many of the challenges associated with the transfer of health information across state lines, it would also allow the consumer to only indicate "health accounts" she/he wants the treating team to see.
What are the incentives to such a system? Hospital A would be compelled to participate because of fear that non-compliance would result in a consumer choice against the organization in the future and because the transfer is associated with a minimal fee (similar to using a foreign ATM) for Hospital A not charged to the requesting consumer but the organization taking care of the patient now (Hospital B). Hospital B will be incentivized because it wants to avoid duplication of effort. Hospital A will receive incentive in form of a fee from Hospital B. The consumer will be motivated to initiate the health information exchange to

reduce unnecessary testing, which reduces time to consumers and cost to payers and consumers. This approach would also eliminate the difficult and error prone patient matching approach used to identify the correct health information for consumers with similar identifiers ("John Smith in Boston", "Maria Gonzales in Los Angeles"). In the light of the recent hacks into federal, commercial, and health insurer databases, this approach provides a federated distribution of health information among hospitals and providers that can be accessed through the consumer and does not offer a single silo that would allow hackers to gain access to millions of consumers at once. We recommend that further development of the ideas above should be undertaken by the multi-stakeholder group suggested in the report to Congress.

Respectfully submitted,



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