



August 15, 2014

The Honorable Chairman Ron Wyden  
Committee on Finance  
U.S. Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510-6200

The Honorable Senator Chuck Grassley  
Committee on Finance  
U.S. Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510-6200

Dear Chairman Wyden, Senator Grassley and Senate Finance Committee Members:

The American College of Physicians (ACP), the largest medical specialty organization and second-largest physician group in the United States, representing 141,000 internal medicine specialists (internists), related subspecialists, and medical students, thanks you for the opportunity to provide input into these very important issues. We appreciate the committee's interest in enhancing the availability and utility of health care data, while protecting patient privacy.

Americans are now living longer and are generally healthier due to healthier life style choices, better screening and prevention, more consistent identification and treatment of key chronic conditions, and advances in heart disease and cancer treatments. We believe that there is real potential for the emerging digital healthcare system to markedly broaden those advances – leveraging electronic health records (EHRs) to help further the consistent application of existing knowledge, and utilizing the EHR as a learning system to more quickly diffuse new knowledge and changes in best practices.

We stress to the Committee, when drafting legislation, to guard against imposing further data collection and reporting requirements upon physicians, as the benefits to patients are unproven, and the impact of the administrative burden and distraction to physicians is clear.

When it comes to the data sources typically used by physicians and other health care professionals to support effective and efficient care delivery, the problem is more often a lack of accurate, actionable, and transparent information, and not simply a lack of access to data. For example, published medication formularies on payer websites may show expensive brand name medications as most preferred – something that would appear to be a mistake. But because formulary decisions are not transparent to doctors or patients – what appears to be a mistake may indeed be correct, reflecting an undisclosed rebate or short term special pricing. Additionally, as pharmacy benefit plans are not currently required to perform any quality checks for accuracy when they mobilize their formularies to providers via ePrescribing networks; what doctors and patients rely upon when making treatment decisions that optimize value, is not only based on nontransparent information, it is wrong. This lack of transparent and accurate information from payers and pharmacy benefits plans results in higher costs,

added work and rework by providers, and delay in patients receiving their necessary medications.

Providers are subsequently burdened with after the fact prior authorization requests. These prior authorization requests – now done primarily via phone calls and faxes, and soon to be online, not only waste time and delay care for patients, they could mostly be made unnecessary if payers provided understandable and usable information PRIOR to testing and treatment decisions. This very approach, one that would speed necessary care to deserving patients and greatly reduce administrative burdens on providers, is being considered by CMS in its new procedures for coverage for certain durable medical equipment.

We urge the committee at the very least, to consider these requirements of transparent, accurate, and usable information available at the point-of-care for Medicare Advantage and Medicare Part D plans.

We further seek the committee's support in helping providers who are currently struggling to use their EHRs more efficiently and effectively. In all industries other than healthcare, where technology adoption and use is time-consuming upfront; it leads to efficiencies down the road – as what is entered can be readily re-used (for example, demographic and financial information for online banking). That is not the case in healthcare, where whatever providers document in their EHRs, they are rarely able to appropriately repurpose that information for payer, employer, and insurer forms or requests. Thus, it is unfortunately all too common that each payer or employer develops its own paper processes, and requires providers to re-enter the same information that is recorded in the EHR on a unique form – thus turning on its head the informatics dictum of “write once – use many times” into “write many times – use once.” At the very least, the federal government should modify its reporting requirements for healthcare related forms to allow for standardized and where possible, electronic reporting.

We urge you to keep the following general concerns in mind as you move forward.

- The focus of what is done must keep both the patient and advancing the patient's health and healthcare delivery at the center. As technology rarely presents a solution within itself, we believe that having a viewpoint that puts technology at the center of one's thinking can add barriers between patients and doctors, and even to necessary care.
- That said, to advance health and healthcare, we cannot continue to add requirements for data collection and reporting that fall on physicians. Before EHRs, physicians used to complain that they “spent more time on paper work than on patient care.” And now with EHRs, the issue is expressed as “spending more time on EHR data collection and documentation than on taking care of patients.” We believe this widely held sentiment has led to a new barrier to physician optimization of health IT in clinical practice, and without reducing this barrier, the chances that new digitally based cures, such as those addressing underserved populations, will be low.
- Historically, in other fields that have experienced technology diffusion, over time IT and new digital workflows have made people more efficient. This has not been the case in medical practice. While EHRs and Meaningful Use have established a framework for making healthcare better and safer, instead of healthcare operations becoming more efficient, they have become less efficient. And while some have blamed the technology for this failing, we believe that the primary cause is the lack of a policy framework and guiding principle that supports optimization of physician time and the patient-physician experience. For example, where most information necessary for prior authorizations is contained within an EHR, payers still require uniquely formatted paper forms.
- EHRs and other physician-facing health IT cannot fix inefficiencies in healthcare operations without cooperation from both public and private payers. Meaningful Use requirements only address physician use of health IT. This imbalance in addressing the healthcare ecosystem has led to this paradox – what should make physicians more

efficient (and thus lead to more time spent in patient care) has instead led to more administrative work and less face time with patients. Health IT would be able to achieve far more in terms of driving recommended care, if this imbalance was addressed and fixed.

- Physicians want and need the ability to use data to learn and to perform better. It is self-evident to thoughtful physicians that data exchange per se does not improve care, and that too much data exchanged too broadly may make it harder to provide good care. This can lead to confusion due to “data overload” and potential misuse and/or misinterpretation of the data.
- The ACP was an early supporter of the objectives of the EHR Incentive program. However, generally, financial incentives are not as helpful as policy makers imagine. Incentives inevitably become penalties. This can lead to gaming behaviors intended to avoid the penalties, thus the behaviors will not result in the desired positive changes.
- We are concerned that, while the government is focusing on the goal of an information-rich healthcare environment, the formats that are being pushed are too often “data rich but information and knowledge/insight poor.” The focus should not be on the volume of data exchanged if these data do not add sufficient value or if they are difficult to find and separate from a large collection of less valuable data, or if the external data are delivered in formats that cannot be easily compared to local data and accurately reconciled. Specifically, a 2103 HHS RFI states, “HHS envisions an information rich, person-centered, high performance health care system where every physician has access to longitudinal data on patients they treat to make evidence-based decisions, coordinate care and improve health outcomes.” This statement contains the underlying assumption that there is a correlation between physicians having a larger quantity of clinical information about each patient, and patients having improved health. In fact, it is possible that such data overload could result in adverse consequences for patient care. More importantly, value-based goals for Health Information Exchange (HIE) should focus on the delivery of services, such as those mentioned below, that facilitate decision-making, facilitate care coordination, and effectively measure and track health outcomes.
- We want to see the government use the levers available to facilitate the kinds of exchange that matter most to patients, and thus to physician efforts to maximize quality, safety and value, such as those listed in the next paragraph. Policies must minimize the number of connections and protocols that practices will have to establish and manage. Currently, many EHR vendors are charging each practice thousands of dollars to establish each connection, and to exchange each document type. Vendors are also signaling that there will be ongoing maintenance charges for each connection for each practice. In addition, vendors are so overwhelmed with work that they are unable to respond to the needs of small practices in a timely manner. There is nothing to be gained from policies that encourage exchange if the exchange partners do not have cost-effective and readily available connections.
- There are many opportunities for valuable exchange that should be encouraged through policy. These include:
  - Directories of provider contact information – complete and up to date.
  - Reliable and accurate patient identification and matching.
  - Rapid notifications of patient care activities such as emergency department arrivals, and admission and discharge notifications to ambulatory physicians.
  - Cross-system management of patient consent.
  - Support for quality measures that track patients across care settings.
  - Data cleaning and standardization services.
  - Management of longitudinal care records.
  - Data analytics, alerts and public reporting services.

The Medical Informatics Committee of the American College of Physicians respectfully submits this letter in the hope that it will assist the Senate Finance Committee in developing plans to advance a legal and regulatory framework that fosters the development of a digital health care

ecosystem, and allows it to serve as a catalyst for the discovery, development, and delivery of new treatments and cures for patients, as well as a usable and useful infrastructure for the more efficient and consistent delivery of existing best practices. Should you have any questions, please contact Thomson Kuhn, Sr. Systems Architect, [tkuhn@acponline.org](mailto:tkuhn@acponline.org)

Sincerely,

A handwritten signature in black ink, appearing to read "P Basch", with a long horizontal flourish extending to the right.

Peter Basch, MD, FACP  
Chair, Medical Informatics Committee  
American College of Physicians