From: (b)(6)
To: CMS No Information Blocking
Subject: Aprima - Data Blocking
Date: Saturday, August 15, 2015 10:05:33 PM
Attachments: image001.png
image003.png
image004.png

This is to report yet another case of EMR/EHR vendor blocking simple and common interfaces to send lab orders and return results.

See a copy of the quote below:

From: (b)(6)
Sent: Friday, August 14, 2015 7:07 PM
To: (b)(6)
Cc: (b)(6)
(b)(6)
Subject: Aprima - Lab Florida integration - Bayada

Hello (b)(6)

Thank you for connecting me with (b)(6) He was very helpful.
Per the specs, a bidirectional Interface can be developed.

The cost is a 1 time fee of $6000 then $1200 per year maintenance and support.
Please let me know if Lab Florida will be contributing any or all of this fee to connect Bayada.

Thank you.

(b)(6)
Aprima Medical Software Inc.
P: 856.340.5479
F: 856.330.9020
E: (b)(6)

aprima EHR • PM • RCM

APRIMA President's Club 2012 2014

Aprima is Meaningful Use Stage 2 Certified

The above represents a common and widely spread block to adoption of these simple interfaces.

We have received similar offers from many vendors, including HealthFusion, eClinicalWorks, Practice Fusion, etc. The cost of the interface is excessive, unreasonable and is a typical case of a vendor proactively blocking the sharing of healthcare information. These interfaces are very common and easy to build. In fact, there is nothing "to build". It took us half hour on the phone and a few days of testing to interface with athenaHealth. No upfront cost and they charge $1 per transfer. That makes sense! And this is the only system we have interfaced.

The $3-7,000 "building charges" and multi-thousand dollar maintenance fees, extra fees per each connection, etc. are cost-prohibitive for independent labs like ours.

We do thousands of PT/INR tests per month. The CMS reimbursement for these is some $4.80. Simple chemistry tests are $10-14. We service about 1,400 providers, over 160 ALFs and over 100 home health agencies in our area. If I have to pay $5-6,000 per connection with each one of them, I can't do any testing! We will never see a return on such investment no matter how many $5-10 tests we result!

All of these interfaces have to be either free or reimbursed to us by CMS, or state or somebody. There is no way we can pay these ridiculous fees!

I hope my vote counts.

Thanks,

(b)(6)
LabFlorida
Laboratory of Florida LLC
7520 W. Waters Ave, Suite 18, Tampa, FL 33615
813.472.7772 | office direct
813.472.7778 | fax
(b)(6)
www.LabFlorida.com | www.MyLabFlorida.com | LinkedIn | Facebook

From: (b)(6)
To: CMS No Information Blocking
Subject: Barriers to Interoperability
Date: Thursday, June 11, 2015 2:02:52 PM
Importance: High

Greetings,

As the Executive Director of the Lewis And Clark Information Exchange (LACIE) that provides health information exchange in both Missouri and Kansas I feel compelled to share the issues we have experienced with Missouri Health Connection (MHC) and their unwillingness to connect to either of the Regional HIOs in Missouri without charging untenable fees.

LACIE has connected to both the Tiger Institute, which is part of the University of Missouri, and the Kansas Health Information Network and approved HIO in Kansas. Connections were made without any fees being charged between the respective HIOs. Over the last 5 years we have offered on multiple occasions to connect to MHC at no charge to promote interoperability for the benefit of patients and providers. The offer has been rejected each and every time. MHC has made it clear they have no real plan to connect with Regional Health Information Exchanges in Missouri. The pricing they have provided in the past was more than our annual revenue to connect.

MHC has also made statements to current and potential LACIE participants that the only way hospitals and providers would be able to obtain/ access Medicaid information in Missouri was through MHC. This propaganda has been supported by the designated state Health Information Technology Coordinator, (b)(6) who also is the Director of the Division of Social Services which has oversight of the state's Medicaid program. (b)(6) also is on the Board of MHC. As the HIT Coordinator (b)(6) has essentially done nothing to promote state interoperability, only promoting MHC.

I have shared my concerns with Ms. Carolyn Coy who is responsible for Missouri. Ms.Coy has been very responsive and on an email dated 2-17-15.

From: Coy, Caroline C. (OS/ONC) [mailto:Caroline.Coy@hhs.gov]
Sent: Tuesday, February 17, 2015 11:22 AM
To: (b)(6)
Subject: RE: Missouri HIO Update

Hi (b)(6)

Apologies for my delayed response. Thank you for reaching out to me, I was wondering how things were going. I did speak with the Missouri REC about the situation and they echoed your initial concerns. I will pass this information along to others at ONC and be in touch.

The initial concerns that I had shared with Ms. Coy included:

As you may recall the Lewis And Clark Information Exchange (LACIE) and the Tiger Institute

(University of Missouri) Health Information Organizations have connected and been exchanging data for over a year. Both LACIE and Tiger agreed to connect to each other without charging any type of initial connection or ongoing fees. We believe that interoperability between HIOs is critical and charging one another for data is a significant detriment to data liquidity.

I have had conversations with Missouri Health Connection (MHC) in regards to connecting in order to be able to share information between our respective organizations, the most recent being January 23rd of 2015. LACIE has offered to connect to MHC at no charge on multiple occasions. To date those offers have been refused by MHC. The response LACIE has received from MHC has been consistent 1.) Pay to connect to MHC, the projected cost to join MHC would be more than our total annual revenue which is not tenable. 2.) Merge LACIE with MHC. There is no interest by the LACIE Board of Directors to merge with MHC. They are confident that the ability we currently have to exchange data between providers in both Missouri and Kansas would be lost and the progress made over the last 4 years to remove information silos would be negatively impacted.

I wish that I had better news to report. LACIE has been very successful in eliminating barriers to information exchange between hospitals and providers in the medical trading area that we serve. We are yet to be able to overcome the significant political and business barriers that have been erected in Missouri in regards to interoperability.

Please let me know if you have any questions or would like to discuss further.

In my opinion MHC has not followed the requirements or the spirit of being awarded over $14M by ONC to promote interoperability in Missouri. I have personally had family and friends negatively impacted do to MHC's unwillingness to exchange information in an attempt to monopolize the market. I would be more than willing to provide additional information/ examples of the barriers to interoperability that have been erected by MHC, especially over the last 2-3 years.

Thank you for your consideration.

(b)(6)

Lewis And Clark Information Exchange

(b)(6)

From: (b)(6)
To: CMS No Information Blocking
Subject: Blocking not only for financial/business reasons
Date: Saturday, August 15, 2015 6:08:21 AM

Hello,

I work in an Australian health system in Queensland, so perhaps this is not directly eligible for the purposes of this data gathering exercise. However, it is of great interest to me due to the relevance of my work in the Clinical Informatics domain. My previous position entailed managing a clinical quality outcomes registry in a surgical programme which also provided data for the secondary purpose of outcomes research. Currently I am a clinical research coordinator, focussing on Clinical Outcomes and Comparative Effectiveness and Quality Improvement studies.

I have experienced repeated situations where senior clinicians obstructed the use of clinical data for research studies which were fully ethics approved and compliant with the best standards for data use. I believe they may have felt their individual results in some outcomes studies (eg use of blood products in surgery) may not appear as well as they would like others to believe, and this leads to blocking of the best use of data to improve outcomes. Similarly, data blocking may occur between related subspecialties where political motives include personal rivalry or competition for eminence.

This is an important aspect that is not well verbalised in this conversation about blocking, because it is not simply business related and demonstrates an even less justifiable motivation in a profession held up as being primarily motivated by the care of patients rather than personal ambition. However the notion that knowledge is power, where data is the foundation of knowledge in healthcare, is relevant beyond the financial aspect; therefore the political and personal impact on physicians, of data sharing and interoperability must also be recognised if data blocking is to be fully addressed.

Best Regards,

(b)(6)

From: (b)(6)
To: CMS No Information Blocking
Cc: (b)(6)
Subject: Concerns about MHC, a Missouri based HIE
Date: Thursday, June 11, 2015 9:16:52 AM

To Whom it May Concern:

My name is (b)(6), and I am president of a startup care transitions company designed to improve the emotional wellness of Heart Failure patients while maintaining their physical health.

CareConnext is a multi-disciplinary, nurse-led intervention combining the power of shared medical appointments with peer-to-peer coaching. Our results were recently published in ***Circulation***, as well as the ***Journal of Cardiovascular Nursing***. Typically we reduce Heart Failure readmissions by 35%, and this effect holds over 7 months. We also increase compliance with vasodilators and decrease depression scores.

We are currently "transitioning" our work from a randomized clinical trial, or RCT, into clinical practice. So far, our results are mirroring those of the randomized clinical trial.

However, one of the key lessons we have learned is the critical importance of relying on shared data transparency to achieve our outcomes

Why? There are two key reasons:

1. We have learned that asking busy clinicians for referrals (even those who champion our efforts) requires too much human intervention.

2. And because our Nurse Practitioners also review recent labs, tweak medicines and order tests, we need up-to-date charts on all patients we see in CareConnext, so that we do not accidentally duplicate or negate the efforts of other providers.

Enter the critical role of data transparency. We are excited to partner with the Lewis and Clark Information Exchange to expand our efforts region-wide. We will use LACIE's database to locate those patients appropriate for CareConnext, and follow up with a personalized letter/invitation from their physician. Once patients complete CareConnext, we will upload our data back into LACIE, and update their clinical teams accordingly.

Everyone wins with this approach: our patients, our providers and the communities we serve.

That said, as President of a healthcare startup, I am dismayed to learn of MHC's business practices:

- No business/ operational plan to connect to other HIOs in the state
- When costs have been quoted they are untenable

MHC costs are routinely more than double that of LACIE's for Acute Care facilities and multiple times more expensive for Non-Acute facilities

- Conflict of interest, Missouri's Health Information Coordinator is on the Board of MHC and is also the Director of Division of Social Services (DSS) in Missouri actively promoting/ selling MHC versus promoting interoperability
- DSS allowing a single source non-bid connection to Missouri Medicaid data and promoting that organizations would not have access to Medicaid data unless they joined MHC

Finally, I understand that MHC has received more than $14M in federal funds and has done nothing to promote interoperability with other HIOs in the state of Missouri. This directly affects patients living in the Kansas City region.

Thank you for allowing me the opportunity to express my concerns in writing.

(b)(6)

Informed Health Solutions

2002 W. 39th Avenue

KC, KS 66103

(b)(6)

View our promotional video here: IHS Promo

From: (b)(6)
To: CMS No Information Blocking
Subject: Data blocking issues with MHC
Date: Thursday, June 25, 2015 2:42:09 PM
Importance: High

To whom it may concern:

Data blocking by MHC does not allow for patient information to be shared for continuity of care of our patients. Interoperability is needed for patient's records to be shared to provide the best, safest, highest quality and lowest cost care that we can provide. We need to do what is best for our patient's! MHC's behavior is not what is in the best interest of the patient!

Primary interoperability issues with MHC

- No business/ operational plan to connect to other HIOs in the state
- When costs have been quoted they are untenable
- MHC costs are routinely more than double that of LACIE's for Acute Care facilities and multiple times more expensive for Non-Acute facilities
- Conflict of interest, Missouri's Health Information Coordinator is on the Board of MHC and is also the Director of Division of Social Services (DSS) in Missouri actively promoting/ selling MHC versus promoting interoperability
- DSS allowing a single source non-bid connection to Missouri Medicaid data and promoting that organizations would not have access to Medicaid data unless they joined MHC
- MHC has received more than $14M in federal funds and has done nothing to promote interoperability with other HIOs in the state of Missouri, which directly impacts organizations in the greater Kansas City Area that may be located in Kansas

Thank you for your time,

(b)(6)

6185 Jefferson Avenue
Parkville, MO 64152

(b)(6)

From: (b)(6)
To: CMS No Information Blocking
Subject: Data Blocking
Date: Tuesday, June 09, 2015 2:43:24 PM

I DO NOT UNDERSTAND WHY WE HAVE FEDERAL DOLLARS GOING TO COMPANIES WHO PERFORM IN THIS MANNER. PLEASE ADDRESS THESE CONCERNS HERE IN MISSOURI ASAP!!

Greetings,

Wanted to reach out to LACIE Board members and participants regarding the data blocking that Missouri Health Connection (MHC) is practicing in the state. As many of you are aware LACIE has offered to connect to MHC on multiple occasions with each of the 4 CEOs they have had over the last 4 years. All off our offers have been refused or not responded to. MHC will only connect to other Regional HIOs in the state if the HIOs to pay untenable amounts (hundreds of thousands of dollars annually) to MHC.

Primary interoperability issues with MHC

- No business/ operational plan to connect to other HIOs in the state
- When costs have been quoted they are untenable
- MHC costs are routinely more than double that of LACIE's for Acute Care facilities and multiple times more expensive for Non-Acute facilities
- Conflict of interest, Missouri's Health Information Coordinator is on the Board of MHC and is also the Director of Division of Social Services (DSS) in Missouri actively promoting/ selling MHC versus promoting interoperability
- DSS allowing a single source non-bid connection to Missouri Medicaid data and promoting that organizations would not have access to Medicaid data unless they joined MHC
- MHC has received more than $14M in federal funds and has done nothing to promote interoperability with other HIOs in the state of Missouri, which directly impacts organizations in the greater Kansas City Area that may be located in Kansas

Currently there is little to no focus on the federally funded HIOs as data blockers/ hoarders. I believe the opportunity below is a good forum to introduce the data blocking issue to a wider audience. I have let Senator Pat Robertson's office know of the issues that MHC is causing with the refusal to connect and exchange data. I have also provided multiple updates to the Missouri project manager for the Office of the National Coordinator, as well as reaching out to over 100 House Representatives in Missouri.

There were also efforts made late in the last legislative session to pass legislation that would move Missouri from a designated entity state, to an approved HIO state, much like the way Kansas operates. The proposed legislation would require all approved HIOs in Missouri to connect at no cost. All approved HIOs would have the same opportunity to access state data and obtain any state or federal funds regarding HIOs. If HIOs are not approved they will have no access to state data or potential funds through the state. Unfortunately the legislation did not make it to the floor for consideration during the most recent session..

Thank you,

(b)(6)

Northwest Health Services
2303 Village Drive
St. Joseph, MO 64506
(b)(6)

From: (b)(6)
To: CMS No Information Blocking
Subject: Data blocking
Date: Friday, August 21, 2015 10:32:54 AM
Attachments: image001.png

One of the biggest offenders in data blocking which is directly related to kickbacks and the unfair competitive edge that those kickbacks provide is Miraca Lifesciences, particularly in their anatomic pathology business dealings. In Miraca's computer interfacing partnership business with the EHR company, Modernizing Medicine (EMA), business schemes are likely illegal and certainly detrimental to the free flow of healthcare data.

For example, my Dermatopathology laboratory paid perhaps $20,000 to build an interface with one of our Dermatologist clients who uses Modernizing Medicine for their EHR. A Miraca (a competitor of mine, like Goliath versus David) salesman comes in to that same Dermatologist client and states that they have a special arrangement with Modernizing Medicine that will allow them to provide faster and easier data accessibility within their EHR. They state that no other laboratory has access to this "supercharged" bit of software, only Miraca Lifesciences.

Hearing this, I call the EHR company, Modernizing Medicine, and tell them that I would like to purchase this bit of software (essentially a small code patch) to allow my lab the same level of interface performance as the Miraca lab. The woman at Moderizing Medicine laughs and says "no, you don't want to buy that software." "Why not," I ask, and the response to me is that this little software patch will cost me more than six figures. Really? Wow.

That's just one example of how these big corporate labs like to play in this evolving wonderful field of free flow of health data. They have uses computer interfaces as a springboard to provide kickbacks to physician users of EHRs.

I can be contacted below as needed.

Thank you for your time

(b)(6)

(b)(6)

Direct Path Services, P.C.
30200 Telegraph Rd Suite 405
Bingham Farms MI 48025
Schwim@dirpath.com
O: 248.220.4425
F: 248.220.4428

(b)(6)

DIRECT PATH

From: (b)(6)
To: CMS No Information Blocking
Subject: Data Blocking
Date: Friday, June 12, 2015 9:04:05 AM

Hi there -

I wanted to share a story of data blocking.

How can my story be sent in anonymously?

We are not interested in the EMR vendor learning our name.

Thanks
(b)(6)

--

(b)(6)
Privia Health, LLC

950 North Glebe Road | Suite 4000 | Arlington, VA 22203
(b)(6) | f: 202.350.9504 | e: (b)(6) www.priviahealth.com

From: (b)(6)
To: CMS No Information Blocking
Subject: eclinical Works ECW data blocking
Date: Wednesday, June 24, 2015 12:51:03 AM

We were unable participate with the Pinicale data base unless we changed from Cloud based server to an actual server or pay a large monthly fee

We have been trying for 4 months to arrange direct HIS email to transfer records outside of our system and have made no progress

Sent from (b)(6)

From: (b)(6)
To: CMS No Information Blocking
Subject: eClinicalWorks information blocking
Date: Friday, July 10, 2015 10:19:33 AM

Hello,

I have just been made aware of this avenue of reporting health information blocking.

We have experienced such blocking when working with eClinicalWorks in our attempt to connect a cardiology practice to Pinnacle - the de-facto national cardiovascular data registry. eCW refused to provide a "read only" username / password for the Pinnacle software. They tried steering the practice towards a "jack of all trades" registry that did not even remotely have the cardiology experience the practice needed. It took the practice months of speaking to various eClinicalWorks engineers that would postpone and play various tactics to delay the project. In the end eClinicalWorks told the Cardiology practice that they were not to connect to the Pinnacle cardiology registry.

It was a awful experience where the practice felt like they were held prisoners to the eClinicalWorks demands and they could not Meaningful Use requirement for connecting to a specialized registry.

I can provide more details if needed.

Thank you.

(b)(6)

(b)(6)
http://www.infomedtrix.com

From: (b)(6)
To: CMS No Information Blocking
Subject: Example of Blocking, skipzix
Date: Monday, August 10, 2015 1:12:51 PM

Mr. Slavitt,

I am emailing you in response for the request for examples of data blocking. I am the Laboratory Manager for a small rural hospital (25 beds) in WV. Our community has physician practices which utilize PracticeFusion as their EMR. These practices have expressed interest in sending their specimens to the hospital laboratory for testing but will not do so without an interface, which is very understandable. Our hospital uses CPSI (Evident) as our Laboratory Information System (LIS). CPSI (Evident) cannot interface with PracticeFusion. I have never been given a reason as to why. I do find it interesting that PracticeFusion is an affiliate of LabCorp.

In the past 5 years I have lost an estimated 40% of my outreach testing from our local physician practices to LabCorp. The revenue from laboratory testing is needed to help keep the doors of our small hospital open. Competing with a large conglomerate like LabCorp is getting very difficult. I often use the example that we are the small family own business that is now completing with Walmart. We don't have a leg to stand on. Luckily our small hospital is financial strong. We just build a brand new facility. Most are not. I can tell you without our hospital most of our patient would not get the health care treatment they need, especially when they have a chronic condition that requires frequent treatments. Most of our patient would have to drive a minimum of 45 minutes to get to another hospital, which is not feasible.

Thank you for time and interest in this topic. If you have any other questions, please don't hesitate to email me.

Best Regards,

(b)(6)

(b)(6)

Office: (304) 329-2222 x 3310

Preston Memorial Hospital
Mon Health System
We've moved to 150 Memorial Drive!

---

you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: (b)(6)
To: CMS No Information Blocking
Subject: examples of data blocking from independent dermatopathology laboratory
Date: Tuesday, August 18, 2015 1:32:47 PM

Dear Dr. DeSalvo and Mr. Slavitt,

I am the Laboratory Director for an independent, community based, dermatopathology laboratory. We provide diagnostic skin pathology reporting to clinicians in the East Tennessee area. I have experience with three examples of data blocking by EMR vendors and users.

1) I was asked to provide pathology reporting for Dr. Tom McDonald, a gyn oncologist in the Knoxville area. He was moving his practice and was looking to use "Practice Fusion". He wanted a bi-directional interface for this pathology work. Practice Fusion was being offered to him free of charge. Practice Fusion offered an interface for about $13,000 up front. There would be an additional monthly transaction fee. Since (b)(6) would only be sending a few biopsies per month, this was not feasible. (b)(6) no longer sends any pathology to our laboratory.
2) I have several clinician clients who belong to Summit Medical Group in Knoxville. I asked Summit to allow our laboratory to set up an interface with their EMR system. Summit refused because our laboratory was "too small". We continue to receive specimens from Summit clinicians, but we report by paper.
3) We have several clients using "EMA" by Modernizing Medicine. For each client we were charged an interface fee up to $3000. We are also charged an annual fee and monthly transaction fees.

In our experience with multiple EMR vendors and clients, there is mostly an unacceptable burden placed on the laboratory. In years past, when it was permissible, many clients demanded the laboratory to pay for the entire EMR product. This introduced a perversion of quid pro quo in the laboratory market. While this provision of EMR to clinicians is no longer permissible, EMR vendors still leverage payments from laboratories for interface services to their clients. The payments are far in excess of costs, and place an unfair burden on small, independent laboratories.

Thank you for your efforts and service to our profession and country.

Sincerely,

(b)(6)
Knoxville Dermatopathology Laboratory
KDL Pathology
315 Erin Drive
Knoxville, TN 37919

From: Mahler, Karson F (HHS/ONC)
To: CMS No Information Blocking
Subject: FW: Data Extraction Issues from EHR software vendor
Date: Wednesday, June 24, 2015 2:29:50 PM
Attachments: image004.png

From: ONC Request (HHS/OS)
Sent: Wednesday, June 24, 2015 11:59 AM
To: Morton, Alicia (OS/ONC); Mahler, Karson F (HHS/ONC)
Cc: Ashkenaz, Peter (OS/ONC)
Subject: FW: Data Extraction Issues from EHR software vendor

This came in the ONC mailbox. I can't imagine it's a unique or rare. EHR vendor is charging $5000 to give a practice their health data. Please take a look and let us know how to respond.

(b)(6)

The Office of the National Coordinator for
Health Information Technology

330 C Street SW | Washington, DC 20201
tel 202.279.1728

Website | Email | Map

From: (b)(6)
Sent: Tuesday, June 23, 2015 8:15 PM
To: ONC Request (HHS/OS)
Cc: (b)(6)
Subject: Data Extraction Issues from EHR software vendor

We are writing requesting help and/or guidance from your office with an issue we are having trying to switch from one EHR software vendor to another.

We have been with our current EHR software vendor, Prime Clinical, since 2013. Prime Clinical's software system is now quite dated and is no longer able to suit our specialists' needs. Additionally, Prime Clinical has struggled to keep up to date with CMS reporting requirements and is currently not in compliance. We need meet our 2015 attestation and we cannot do this due to non-compliance and the software's inability to pull the required reports.

We have chosen another software vendor, Nexus Clinical, that is able to better meet our needs and reporting requirements. We are trying to transition over to the new software before September so that we will have enough data collected to do our required reporting. However, Prime Clinical is REFUSING to give us our data unless we pay them $5000 and then are only providing limited data such as Patient Demographics and Appointments. We

had an attorney read through the contract we signed with Prime Clinical and it clearly states that we OWN the data and it never indicates that we would have to PAY to extract it.

However, this does not get us the actual patient clinical data. Patient Clinical Data includes clinical notes, radiology reports, operative reports, etc. Without this data, we cannot treat patients. Prime Clinical has indicated that our office will need to manually go into each patient's file and email every document to ourselves. We have **10,000 patients** in the system and with only 10 staff members this is impossible.

We know much of the Patient Clinical Data is in an extractable table format as we were able to run reports off of it for CMS requirements in 2013 & 2014. Sending us this data in PDF format is not useful nor could we do this ourselves.

Prime Clinical further let us know that perhaps they could develop a method to extract patient clinical information but it would cost us an additional $20,000 - $25,000!!! We are a small office of 2 providers, we cannot afford this. The information would still be in PDF format and could not be automatically downloaded into our new system.

The new vendor, Nexus Clinical, has offered to work with the old vendor, Prime Clinical, to come up with a method to get the data. Prime Clinical REFUSES to cooperate. Are Prime Clinical's actions legal? Can they hold our office hostage like this? What options do we have?

We look forward to hearing from you on this matter.

(b)(6)
Temecula Valley Neurosurgery
25150 Hancock Ave #210, Murrieta, CA 92562
(b)(6) | P: 951-587-3739 | F: 951-698-5213
TEMECULA VALLEY NEUROSURGERY
COMPLEX SPINE & BRAIN SPECIALISTS
www.tvneurosurgery.com

From: (b)(6)
To: CMS No Information Blocking
Subject: Hospitals don"t want to share
Date: Friday, December 18, 2015 5:12:32 AM

I request hard copy's of lab and tests results...
In other words, I have my own medical records...Dates of lab work etc...save Medicare money...

(b)(6)

Sent from my iPad

From: (b)(6)
To: CMS No Information Blocking
Subject: information blocking
Date: Wednesday, December 09, 2015 6:43:03 PM

Saint Peter's Hospital in Helena, MT is extremely poor at sharing information

May your holidays be filled with joy!

(b)(6)

(b)(6)

Lead Nursing Home Quality Improvement Specialist

Mountain-Pacific Quality Health

3404 Cooney Drive | Helena, MT 59602
Ph: (406) 457-5885 | (800) 497-8232 ext. 5885 | Fax: (406) 513-1920 | www.mpqhf.org

From: (b)(6)
To: CMS No Information Blocking
Subject: interface fees
Date: Wednesday, August 19, 2015 2:05:57 PM

We are a small privately owned independent pathology laboratory (8 physicians) in a more rural area of Northern California. We currently have 7 result interfaces in place. We had a policy of not paying maintenance fees or support fees or transmission fees but have found ourselves having to change our policy or lose clients. We have also had success with a couple clinicians/facilities being willing to bear the burden of their EMR vendor costs with us paying for our vendor interface costs but again, that has changed in the recent years and we have had to pay a significant amount of interface development costs.

Here are three particular situations we have recently encountered:

A. One of the difficult EMR vendors we dealt with was a popular dermatology practice EMR. They charged an $8000 fee to establish a bi-directional interface (this did not include the costs paid on our side to build the interface) and we also have to pay a $1.35 per result fee per month and a $1000 annual maintenance fee. We used a well-known attorney to review the contract and to argue the per result fee but we were unsuccessful and eventually had to agree to pay their required fees.

B. Another vendor charging connectivity fees plus result fees is a web-based solution. They are charging a one-time, non-refundable fee of $10000 for each interface, along with monthly "network activity fees" for each electronically transmitted result. The monthly fee ranges from $20 to $120, depending on volume of transmissions.

C. We are currently in discussion with a client who is using a very large EMR vendor company, who uses a middleware. We were originally quoted (by the middleware vendor):

1. $16000 for a bi-directional "kit development" (a one-time fee for the first interface built) plus
2. $8000 for the bidirectional implementation (this would be for each interface built using the middleware vendor) – (first interface cost $24k) plus
3. $4000 annual maintenance plus
4. $3000 annual fee for Lab Medical Necessity Rules Subscription

After discussions regarding the large fees, we are now being quoted:

1. $14000 for a bi-directional "kit development" (a one-time fee for the first interface built) plus
2. $6000 for the bidirectional implementation (this would be for each interface built using the middleware vendor) plus
3. $2800 annual maintenance fee for each interface plus
4. $3000 annual fee for Lab Medical Necessity Rules Subscription

The difficulty is that the EMR vendors tell their customers that the "labs will pay all the interface costs," which is very financially challenging for small businesses such as ours. We risk losing clients if we are not willing to pay. And the above fees do not include the connection costs we pay for

"our side" of the interfaces.

If we can answer any further questions please contact me directly.

Sincerely,

(b)(6)
Pathology Sciences Medical Group
(b)(6)
phone 530-891-6244
fax 530-891-0134

From: (b)(6)
To: CMS No Information Blocking
Subject: Interoperability barriers- Pathology practice in NC
Date: Monday, August 17, 2015 12:06:02 PM

Dear Mr. Slavitt/CMS:

I read with interest your comments reported as follows; *"We would like to hear about every example—small, medium, large—when someone is getting in the way of interoperability. We want as a team to hear about these examples and confront them."*

I am a pathologist operating a diagnostic laboratory service. We diagnose skin biopsies including cancers such as melanomas and other malignancies for client dermatologists located in multiple community based offices.

Since electronic medical record (EMR) adoption commenced several years ago, we have interacted with EMR vendors selected by our referring dermatologist offices, and some hospital based EMRs (especially EPIC). We've experienced marked variation in performance and pricing structures among these vendors. Some of the variation appears to be dependent on technical configurations, but other times the huge financial / pricing hurdles appear more opportunistic on the part of the vendor which now has sole control over a key part of the information pathway.

I would like to share this information with you, but regret that contract terms with the most difficult EMR company we have tried to deal with prevent me from providing that information to you. If an interested government agency required me to disclose certain information about a contract or contracts, I would certainly comply.

Sincerely

(b)(6)

Cutaneous Pathology PA
Winston-Salem NC

From: (b)(6)
To: CMS No Information Blocking
Subject: Kaiser ineffiency
Date: Monday, October 26, 2015 8:32:31 AM

Recently I moved to a new location after 30 years at the same facility, interviewed a new doctor, and was dismayed to find she couldn't access important epically history - X-rays following an auto accident, notes and blood tests relating to long term illness. In querying medical records dept, was told that these items were "in storage", and could "possibly be dug out".

Since I plan on leaving Kaiser and enrolling in a Medigap plan plus a supplement, I would like my new doctor to have access to important medical history. I'm entering my mid-seventies, just ahead of a large population of aging Boomers. It's going to be critical for our medical history to be available within and across channels as a we live longer, and hopefully healthier, lives.

I salute your efforts, and would be grateful for any assist and you might provide in helping me access important documents, bringing them, as it were, "out of the closet".

Appreciatively,

(b)(6)

Sent from my iPad

From: (b)(6)
To: CMS No Information Blocking
Subject: Local information Blocking
Date: Thursday, June 04, 2015 9:36:52 AM

I am a solo practicing physician in Michigan. My office EMR is Athenahealth. This EMR has a robust patient registry. I am a member of United Physicians PO....their population management company is Wellcentive. The interface to Wellcentive was set up through Covisant....I was left in a position where United Physicians wanted me to enter all my patient registry data by hand into Wellcentive....I refused and requested an interface be set up between Athena and Wellcentive, through Covisant...Athena prides itself in meeting all interface requests of its local clients. After trying for four years to develop this interface with United Physician/Covisant/Wellcentive I have given up....It has come to my attention that United Physicians no longer is contracted with Covisant and is going it on their own (whatever that means). I trust this will be a good example of blocking. Although this word was never used trying to build this interface, still, I can't help but think that the block was business related and not technical. (b)(6)

(b)(6)

From: (b)(6)
To: CMS No Information Blocking
Cc: (b)(6)
Subject: Missouri Health Connect Business Practices - Data blocking
Date: Tuesday, June 09, 2015 3:15:36 PM

Sir:Madam

This email is in response to your solicitation for examples of data blocking.

Missouri Health Connect routinely and persistently engages in this behavior impeding the free flow of information in the Kansas City Metro area and through Missouri.

LACIE is a regional exchange serving nearly 2 million lives on both sides of the border around Kansas City, Missouri and Kansas.

We have on multiple occasions offered to connect to MHC for the symmetrical exchange of data for no cost. We have been rebuffed over the course of 5 or so years and 4 CEOs.

We seek your help in encouraging this organization to serve the needs of patients in our region and across the states.

Thanks

(b)(6)

(b)(6)
Lewis and Clark Information Exchange,
Kansas City, Missouri

(b)(6)
CMIO – University Kansas Health System
(b)(6)

From: (b)(6)
To: CMS No Information Blocking
Subject: Missouri Health
Date: Tuesday, June 09, 2015 12:03:58 PM
Importance: High

MHC's HIE with access to Medicaid data is holding the rest of the state hostage. There will be not access unless a large fee is paid to MHC plus transitions fees. Was the HIE met to line the pocket or provide. MHC has refused to work with other regionals HIEs without money. MCH is not interoperability. The primary interoperability issues with MHC

- No business/ operational plan to connect to other HIOs in the state
- When costs have been quoted they are untenable
- MHC costs are routinely more than double that of LACIE's for Acute Care facilities and multiple times more expensive for Non-Acute facilities
- Conflict of interest, Missouri's Health Information Coordinator is on the Board of MHC and is also the Director of Division of Social Services (DSS) in Missouri actively promoting/ selling MHC versus promoting interoperability
- DSS allowing a single source non-bid connection to Missouri Medicaid data and promoting that organizations would not have access to Medicaid data unless they joined MHC
- MHC has received more than $14M in federal funds and has done nothing to promote interoperability with other HIOs in the state of Missouri, which directly impacts organizations in the greater Kansas City Area that may be located in Kansas

Take the chains away and give the money to Regional Missouri HIEs will to work together.

From: (b)(6)
To: CMS No Information Blocking
Cc: (b)(6)
Subject: Our Antiquated Administrative Transactions
Date: Wednesday, June 17, 2015 5:47:47 PM
Attachments: Comments to NCVHS Subcommittee on Standards.pdf

As Andy Slavitt recently said at the HIMSS conference "We don't experience care in silos and our data can't live in silos." Despite this, our healthcare industry continues to move at a snail's pace in modernizing our administrative transactions.

Consumers are moving to high deductible plans and providers are moving towards value-based payment systems. These critical parts of our nation's efforts to rein in healthcare costs cannot succeed unless consumers and providers have access to information about healthcare costs and quality.

Plans are moving towards narrower networks, providers are joining accountable care organizations, and benefit plans are being fine-tuned to specific needs. All valuable and positive steps, but they will only add complexity to an already complex and convoluted system, one described as "being where financial services was 25 years ago."

Despite this, efforts to streamline our administrative standards are frozen in time. The standards organizations are recommending against incorporating the new health plan identifier in the administrative transactions. Despite claims to the contrary, the healthcare industry continues to block calls for a standard payer identifier to enable the electronic routing of transactions.

We continue to believe transparency is essential and inevitable, but it will require leadership from the administration. Simple questions, such as verifying that a provider participates in the network for a consumer's healthcare plan, are made orders of magnitude more complex without the widespread use of standard identifiers for plans and for payers and industry directories to reliably route those transactions.

The National Center for Vital and Health Statistics is holding hearings this week on the effectiveness of our administrative transactions. We continue to urge CMS and the administration to renew their focus on these issues as an essential step towards modernizing our healthcare system. Please see our attached letter to NCVHS for more specific recommendations on how we can move forward.

Thanks

(b)(6)

-

(b)(6)
Business Architects
(b)(6)
www.busarch.com

(617)388-3717

From: (b)(6)
To: CMS No Information Blocking
Subject: PracticeFusion Blocking
Date: Monday, August 10, 2015 2:06:57 PM

NoInformationBlocking:

I work in Technical Support for a company that is in the business of reading healthcare data into our system and forwarding it on to other systems in the standard HL7 format. We were helping PracticeFusion send data to several labs after doctors would enter orders for tests in their software. My knowledge is not perfect but I have heard that they cut off our connection to the data. I don't know how they're getting the doctor entered data to the lab now but in some cases, it is not through us. In at least one case I'm aware of, a mutual client was using the combined PracticeFusion/Atlas software to get doctor orders for tests to a lab and also to a label printer. When PracticeFusion cut us off in this case, the client was no longer able to get the labels printed and called me to ask for help. I'm not sure if the doctor's orders were going over to the lab either but since we were cut off, there was nothing we could do except give the tech support line for PracticeFusion.

Atlas may not be a very big company and it may not always be doing the most economically beneficial things in the short term but I have to tell you that I feel really great helping us keep healthcare data in standard formats so that things can work smoothly. Capitalism is terrible at this sort of thing. Different sized railroad tracks have attracted the attention of lawmakers in the past and it's to be expected that some data formats will attract similar attention. It's nice to see lawmakers paying attention to this issue. I wish you the best of luck with your efforts.

Regards,

(b)(6)

Atlas Medical
26679 W. Agoura Rd., Calabasas, CA 91302
office: (818) 224-6264 | cell: (b)(6) | fax: 818-340-7079
email: (b)(6) website: www.atlasmedical.com

ATLAS® MEDICAL
A division of Atlas Development Corporation

From: (b)(6)
To: CMS No Information Blocking
Subject: questionable subscription fees from EHR vendor to share clinical data for MSSP
Date: Wednesday, June 03, 2015 7:44:57 PM

Hello:

First of all, thank you for looking into information blocking practices more aggressively.

I would like to make you aware of a current business practice that in my humble opinion is inappropriate. It is not information "blocking" per se, rather it is information sharing at a price that is not very scalable.

My employer Mercy Health is building a CIN across multiple markets in Ohio. Our MSSP, Mercy Health Select, has over 75K members, and we just submitted our NextGen ACO application. Our enterprise EHR is Epic and our data aggregator and Pop Health Platform is Explorys. Like most other ACOs we have a laundry list of other ambulatory EHRs we are trying to pull clinical data from in order to meaningfully transform the delivery of care and achieve Triple Aim.

Some of these EHR vendors provide the data for no additional fee at all, and some charge a nominal fee. Recently we began discussions with eCW, who requires a formal contract in order to provide data to support MSSP measures. There is a one-time set up fee which is reasonable, and there is also a maintenance subscription. I don't have a problem with the concept of a maintenance subscription, but I do have a problem with the amount. eCW is requiring a subscription fee of $900 per provider per year. That is more than we pay Explorys per provider per year. So, we would be paying eCW more money for a flat file subscription than we pay Explorys for complete Pop Health Platform functionality, to include aggregation of clinical & claims data, risk scores, registries, identification of care gaps, ad-hoc analytics, etc.

One of our consultants tells us we need to budget $1,000 per provider per year for pop health IT services. That sounds about right considering what we pay Explorys, along with a few other tools we use that I won't go into here. Obviously, the eCW subscription would blow up that benchmark.

We are "courting" one practice on eCW with over 100 physicians. Should we have to pay more than $100K annually, just to get their clinical data in a flat file? Seems pretty steep to me.
I am not attaching it here, but I would be happy to provide the contract paperwork eCW sent us if you are interested to see it.

(b)(6) | Mercy Health
O: 513-639-0500 | C: (b)(6) | http://www.linkedin.com/in/jdwhitlock

From: (b)(6)
To: CMS No Information Blocking; Mahler, Karson F (HHS/ONC)
Subject: RE: eClinicalWorks information blocking
Date: Wednesday, August 12, 2015 9:54:30 AM

I am including Karson Mahler. Depending on the type of interface Pinnacle had planned, eCW may not be using the features certified for data exchange. For example, this practice was using CDAs to send to pinnacle, or electronic lab reporting- both of which are certified components of the ONC certification program, and eCW was not making these available, the practice could file a complaint with the appropriate certification body.

(b)(6)

Office of the National Coordinator of Health IT
W 202-205-4528
C (b)(6)

From: CMS No Information Blocking
Sent: Tuesday, August 11, 2015 3:53 PM
To: (b)(6)
Subject: FW: eClinicalWorks information blocking

Any thoughts?

From: (b)(6)
Sent: Friday, July 10, 2015 10:19 AM
To: CMS No Information Blocking
Subject: eClinicalWorks information blocking

Hello,

I have just been made aware of this avenue of reporting health information blocking.

We have experienced such blocking when working with eClinicalWorks in our attempt to connect a cardiology practice to Pinnacle - the de-facto national cardiovascular data registry. eCW refused to provide a "read only" username / password for the Pinnacle software. They tried steering the practice towards a "jack of all trades" registry that did not even remotely have the cardiology experience the practice needed. It took the practice months of speaking to various eClinicalWorks engineers that would postpone and play various tactics to delay the project. In the end eClinicalWorks told the Cardiology practice that they were not to connect to the Pinnacle cardiology registry.

It was a awful experience where the practice felt like they were held prisoners to the eClinicalWorks demands and they could not Meaningful Use requirement for connecting to a specialized registry.

I can provide more details if needed.

Thank you.

(b)(6)

(b)(6)

http://www.infomedtrix.com

From: (b)(6)
To: CMS No Information Blocking
Subject: Significant problems with auditing
Date: Wednesday, June 03, 2015 9:47:12 AM

I was hospitalized at Swedish Hospital in Seattle. I reviewed the physician charges by Swedish Medical group and found significant errors in charges. There were charges from physicians I never saw on those days, double billing and upcoding of charges. I requested an insurance company audit of all charges. Blue Cross Blue shield performed no auditing. The sent me a totally indecipherable excel sheet. I believe many hospitals are over billing significantly. There is no one paying attention at insurance companies to this over billing, and then they want to increase already unaffordable premium rates.

Swedish eventually corrected some of their errors, but not all.

Additionally I had significant post operative complications due to the poor care at this hospital that is a procedure mill. There is no way to report or hold this hospital, and its personnel accountable. I am still dealing with the sequelae, and it will most certainly affect my life expectancy. The cost of their errors increased my bill from $100,000 to now over $300,000 not to mention the effect that it has had on my overall health. It took significant time to go over the medical record to address these issues, not to mention the hours on the phone that it tooiqThere must be better accountability by all parties.

(b)(6)

From: (b)(6)
To: CMS No Information Blocking
Subject: Solstas and Lab Corp
Date: Wednesday, June 03, 2015 9:11:10 AM

We have Meditab IMS software and want to integrate lab ordering and reporting. Both of these companies want to charge excessive and unnecessary fees to do this when we all know it has been done 100s of times previously and really no need to charge anything since they make profits off the labs we order. Meaningful use requirements means we are a victim of extortion.

(b)(6)
Hickory Allergy and Asthma Clinic
220 18th Street Circle SE
Hickory, NC 28602
828-322-1275

HICKORY
Allergy, Asthma & Sinus
breathing is a breeze

From: (b)(6)
To: CMS No Information Blocking
Subject: South Texas Radiology Inaging Centers (STRIC) data blocking
Date: Friday, June 12, 2015 9:46:10 PM
Attachments: image002.png
image003.png
image004.png
image005.png
image006.png

Good evening

I am a board certified radiologist and clinical informatist. My company listed below has established a private health information exchange serving San Antonio and South Texas. We have developed a secure web based platform that facilitates the data sharing or interoperability of 9 outpatient imaging centers and the network of medical providers. We are big champions of interoperability.

The largest radiology group in San Antonio and South Central Texas is South Texas Radiology Group. In order to prevent patient records from being transferred from STRIC to any other medical facility, STRIC made a corporate decision to apply a proprietary lock to CDs containing patient records. This lock is not applied to CDs of physicians that refer to STRIC but us applied to CDs provided to other medical entities including hospitals or imaging centers and to physicians that do nor refer regularly to STRIC.

We have submitted records requests to STRIC signed by the patient requests delivery without the STRIC applied proprietary lock but have received only a locked CD which means the information can only be viewed and not transferred. This is clearly an example of information blocking in attempt to gain business advantage because the patient must return to STRIC for follow-up studies. The requests that we made were for Medicare patients.

I would be happy to provide additional information. We need unimpeded sharing of information for the benefit of all patients in San Antonio.

(b)(6)
(b)(6) Musculoskeletal Imaging Consultants
ABR Board Certified: Diagnostic Radiology
ABPM Board Certified: Clinical Informatics
(b)(6)
toll free: 866-690-0008
cell: (b)(6) | fax: 210-579-1012
www.msktelerads.com