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Governor's Office of Health Care Reform
1 Commonwealth Avenue
Harrisburg, PA 17120

To whom it may concern:

MobileMD respectfully submits the following comments with respect to the Governor's Office of Health Care Reform ("GOHCR")'s Proposed Strategic Plan for a Pennsylvania Health Information Exchange ("PHIX") (the "Plan"). In short, the plan concerns me as an entrepreneur and Pennsylvania resident. For many reasons, the Plan should be withdrawn, and I propose state and federal funds to be used to establish PHIX should be used to incentivize Pennsylvania Health Systems to establish standards-based exchanges capable of leveraging the NHIN-CONNECT infrastructure. In doing so, the goal of improving the secure exchange and access to critical health information can be achieved, while avoiding an arbitrary top-down approach that suggests "one size fits all".

Perhaps most troublesome is a statement found on Page 40 of the plan, which states: "In order to reduce implementation time and reduce costs, Pennsylvania should execute an intergovernmental agreement with Delaware to leverage their existing contract for HIE Services." The proposed plan, however, lacks an explanation as to why Pennsylvania should not create an HIE contract suited to Pennsylvania or why the Delaware contract is the most suitable HIE contract among myriad such contracts to "leverage." Although not mentioned in the Plan, HIMSS' *Government Health IT* publication has pointed out that the Delaware "... infrastructure includes the HIE application developed by Medicity and hosting services from ... Dell Services." The Plan's recommendation, therefore, would result in the arbitrary selection of Medicity as the state-wide health information exchange platform for Pennsylvania without any competitive bidding process or other reasonable objective vendor selection process. This eventuality is potentially sweeping in its implications. If Pennsylvania can forego the competitive bidding process in order to reduce implementation time and costs, why would we need the Commonwealth Procurement Code at all? Wouldn't it always reduce implementation time and costs to simply bypass the competitive bidding process and use another state's contract?

It is my understanding that, under the Commonwealth Procurement Code, unless otherwise authorized by law, any Commonwealth agency contract (which is "a type of written agreement, regardless of what it may be called, for the procurement or disposal of supplies, services or construction . . .") shall be awarded by competitive sealed bidding except in the event that competitive electronic auction bidding or competitive sealed procurements are permitted or in the case of small, emergency and sole source procurements. There is no indication that the Plan would involve a small or emergency procurement. At the December 16th meeting, the presenters indicated that they had "not done anything yet." But, a news interview of one of the presenters indicated that a decision has already been made to forego competitive bidding. If

that is the case, and the GOHCR intends to seek sole source procurement under 62 Pa.C.S. § 515, please provide the written determination authorizing sole source procurement. Although we are submitting a separate request for information pursuant to the Pennsylvania Right to Know Law to Greg Howe, we would certainly appreciate being provided with all information, electronic or digital communications and documents: (a) relating or containing communication about the Plan between any PA employee or representative and Delaware, Medicity and/or Dell Services; (b) relating to the Plan; (c) relating to or containing intergovernmental communication with respect to the Plan; or (d) relating to or containing communication received by the Commonwealth with respect to the Plan.

With due respect, the Plan seems wrong in at least four respects. First, the very notion that the state would let a no-bid contract of such a scale with so much at stake for the well being, privacy and quality treatment of Pennsylvania citizens is very disconcerting, and, frankly, jeopardizes the trust Pennsylvania providers and patients have in the GOHCR's judgment – trust critical to ensuring the technology adoption and subsequent benefits GOHCR seeks.

Second, based on extensive experience in this field, I question the manner in which many state-bounded health information exchange initiatives have unfolded. All too often state-wide initiatives such as the proposed GOHCR plan fail to appreciate the real-world regionalization of healthcare. While healthcare is clearly a regionally-based market, health system boundaries regularly cross state lines, particularly in the crowded Mid Atlantic and Northeast regions. As a result, there are numerous technical, operational, legal, and regulatory issues that require rigorous analysis. The plan lacks any evidence of such analysis, and GOHCR, by its own admission, doesn't plan to consider the detailed operational issues until March, 2010. Moreover, GOHCR, by its own admission, indicated during the December 16th information session that Delaware's exchange will be separate from Pennsylvania's. Pennsylvania is, therefore, only leveraging the technology implemented by Delaware. This fact indicates the proposed plan and intergovernmental arrangement with Delaware isn't supportive of advancing regionally practiced medicine that crosses state lines, since Delaware is a bordering state, and in fact, borders the most populous region in the entire commonwealth.

The current state-based initiative in Tennessee, for example, is experiencing several challenges. Tennessee is bordered by eight (8) states. Tennessee's population exists largely along its state lines. As a result, many Tennessee-based health systems provide services to physicians and patients in bordering states. Due to its need to extend beyond state lines, the Tennessee initiative has experienced challenges such as varying privacy rules between bordering states, and funding constraints that stop the flow of capital at the state line. Increased expense, confusion, and poor technology adoption has been the result. In short, state boundaries are arbitrary in the context of health system referral regions.

Third, the Plan fails to address specific operational considerations critically important to those who intend to participate. Essentially, two questions must be asked: is free really free? And, how can GOHCR possibly make an informed decision before such operational issues are more thoroughly understood? Below represents a **tiny fraction** of the operational questions that must be addressed by GOHCR, the answers to which will most likely imply costs to the health systems, practices and other participating entities that will be very difficult for the GOHCR to quantify.

1. Who is going to actually work with the exchange vendor to support the individual subscribing entities?
2. Who is going to work with the various physician communities when questions arise regarding status of anticipated results and reports?
 - a. For example, who is going to take the call from the remote PCP when she is asking about Mrs. Jones' Discharge Summary?
 - b. For example, who is going to communicate with the exchange vendor when subscriber interfaces have to change because internal systems have changed?
3. Who is going to organize physician and community outreach programs to make potential subscribers aware of the offering?
4. Who is going to manage the technology components that are deployed on site at the subscribing entities, whether the components are hardware devices, software or both?
5. Who is going to handle user provisioning?
6. Who is going to handle integration mapping – whether it can be done by a user interface or programmatically?
7. Who is going to support branding and private labeling to the local health system communities so a sense of brand recognition remains?
8. Are the service levels for different healthcare organizations different? If so, who is going to manage that rather complicated matrix?

These and similar questions require significant thought, rigor, and entity-specific considerations. As a result, the time to work out operational considerations will be considerable. If, for example, addressing such questions takes 10 – 12 months, is the GOHCR really saving time by circumventing the traditional open bidding process? I respectfully submit the answer is no.

Fourth, my business experience in general and my experience in the healthcare industry in particular has convinced me the best results are obtained when health systems are left free to choose how to solve their information technology needs, and do so in a manner that provides competitive advantage. As a means of further making my point, allow me to quote Adam Smith, the founder of modern capitalism. “It is not from the benevolence of the butcher, the brewer, or the baker, that we can expect our dinner, but from their regard to their own interest.” For our national drive to modernize healthcare’s information technology infrastructure to succeed, we have to depend upon the “invisible hand” of competition to drive innovation and adoption. The mantra should be “competition first then cooperation”. Health systems should be provided the opportunity to compete for physicians and patients using information technology as a competitive advantage. Exchanges, more than any other type of information technology, provide health systems the opportunity to leverage technological innovation to establish and improve relationships with their physician and patient communities. The inter-system exchange of information will naturally follow, using national standards and freely available infrastructure such as the NHIN-CONNECT, as health systems reach a point at which their physician and patient communities require inter-region cooperation. The health system calculus regarding return on

investment will change accordingly and the “invisible hand” of competition will compel cooperation. Just look at the commercialization of the World Wide Web as the case study.

In summary, if the GOHCR wishes to use state and federal funds to improve the quality of health care by subsidizing Pennsylvania health systems such that adequate information technology is more attainable, I recommend GOHCR provide health systems with financial incentives for health information exchange adoption instead of using expediency as the primary decision making criteria and a sufficient reason to circumvent the competitive bidding processes. By offering Pennsylvania’s healthcare community a single technology choice with a single perspective and approach, the GOHCR fails to grasp an opportunity to encourage innovation. Rather, the default selection of a single vendor stifles innovation and jeopardizes health systems’ ability to adhere to their mandate to provide the best possible care to their communities. In my opinion, the Plan represents an incomplete assessment of the key issues and potential solutions masquerading as a rational decision driven by a need to achieve speed to market.

As a post script, the pool of connected physicians in the state of Delaware is hardly comparable to the needs of Pennsylvania’s legion physicians. Our health information exchange (www.MobileMD.com) has more than 1,000 physicians connected in the commonwealth of Pennsylvania, from Pittsburgh to Philadelphia, and we’ve just begun. By “hanging its hat” on the Delaware initiative as a proof of concept, the GOHCR appears to have failed to conduct appropriate due diligence and deliberation with respect to the challenges facing such an initiative.

Respectfully,

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