AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dec. 22, 2023

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Micky Tripathi
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
330 C St. SW, 7th Floor
Washington, D.C. 20024

Re: RIN 0955-AA05; 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking

Dear Secretary Becerra, Administrator Brooks-LaSure, and National Coordinator Tripathi:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 129,600 family physicians and medical students across the country, I write to provide comments on the recent proposed rule *21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking* from the Centers for Medicare and Medicaid Services (CMS), the Office of the National Coordinator (ONC) for Health Information Technology (IT), and the Department of Health and Human Services (HHS), as requested by the November 1, 2023, Federal Register. The AAFP supports the goals of this proposed rule and appreciates the agencies undertaking this collective effort to define disincentives for the practitioner community and progress the policies authorized in the 21st Century Cures Act.

The AAFP has long supported the agencies' efforts to advance interoperability of health IT, including through ONC's development of information blocking regulations. Interoperability is essential for ensuring family physicians have access to meaningful, actionable data at the point of care, which in turn enables them to provide high-quality, patient centered care across the lifespan. Truly interoperable health records will reduce administrative tasks for physicians, improve patients' access to their health data, and support HHS' goal of transitioning the health system to value-based care. The AAFP agrees with ONC, HHS, and CMS that in order to facilitate information sharing between patients and every facet of the health care system, appropriate disincentives must be in place to prevent information blocking by organizations or individuals. We appreciate the agencies proposing to define several disincentives for a range of clinicians if they were to be found guilty of information blocking. However, the AAFP has serious concerns regarding some of the disincentives outlined in this proposed rule, including those that may disproportionately impact small and independent physician practices, and others that may not be able to achieve the proposal's intent of deterring information blocking. We stand ready to collaborate with the agencies and other stakeholders to

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improve the disincentives proposed in this rule. Among several other recommendations detailed in our comments, **the AAFP recommends CMS, ONC, and HHS:**

- **Implement a corrective action plan (CAP) process for health care clinicians who are found to be guilty of information blocking, including remediation procedures that would offer the opportunity to rectify identified information blocking issues instead of disincentives being imposed.**
- **Enact an appeals process, similar to the appeals process outlined for accountable care organizations (ACOs) in this proposed rule, that would allow all physicians to appeal an initial determination of information blocking or issued disincentives.**
- **Develop an intra-agency communications plan and educational outreach program that focuses on information blocking laws and requirements and is specifically designed to ensure small and independent physician practices are equipped to successfully avoid information blocking penalties.**
- **Monitor whether hospital disincentives sufficiently discourage information blocking, and strengthen disincentives as needed.**
- **Do not finalize the proposed all-or-nothing disincentives for clinicians in the Merit-Based Incentive Payment System (MIPS) and/or Medicare Shared Savings Program (MSSP), and instead consider a scaled approach that takes several factors into account.**
- **Do not finalize disincentives that prevent clinicians from participating in ACOs or other alternative payment models, which will in turn negatively impact patient care.**

Implementing Corrective Action Plan, Appeals, and Educational Outreach Processes Prior to Imposing Clinician Disincentives for Information Blocking

The AAFP urges HHS, ONC, and CMS not to finalize this rule as proposed, with enforcement beginning the day of the final rule's publication. Despite ONC's longstanding efforts to reach and educate the health care community about information blocking, significant knowledge gaps still exist regarding the implementation and enforcement of information blocking regulations. Several independent, small, rural, and solo medical practices are still unaware or underinformed about information blocking requirements. **We urge the agencies not to immediately implement any disincentives for health care clinicians who are initially found to be guilty of information blocking. Instead, a corrective action plan (CAP) process should be implemented, including remediation procedures physicians can use to resolve information blocking issues and avoid being issued a disincentive**. Our proposed approach would enable clinicians to address deficiencies and gain a more comprehensive understanding of current regulations, which will more effectively improve information sharing and avoid disproportionately penalizing clinicians and practices with limited resources.

We propose that for clinicians found guilty of information blocking, a process similar to CMS' Improper Payment Measurements Program's Payment Error Rate Measurement's (PERM) CAP system be implemented. This would also align with the agencies' alternate proposal outlined in the MSSP section of the proposed rule. If a physician was found guilty of information blocking, they would be notified of the violation's details through their Medicare program's normal communication routes, provided resources on how to resolve it, and given 90 days to submit a CAP to OIG. Upon review, OIG would issue a response of 1) an acknowledgement letter stating that the CAP meets all requirements; or 2) a letter advising what areas do not meet requirements and need to be addressed. Physicians would be asked to submit a revised CAP by a due date given in the letter. Once a clinician's CAP was accepted, they would have one calendar year to implement before OIG would review for compliance. CMS would follow up with the physician via email at the midpoint of that calendar year to check on the CAP implementation process and provide technical assistance if needed. If after a year OIG found the clinician to not have implemented their approved CAP and to

still be information blocking, the agency would then refer them to the appropriate agency for disincentives to be applied. This process would offer similar remediation procedures as are available to clinicians in a variety of HHS programs, allowing administrative streamlining and burden reduction for physician practices and agency staff alike. **We strongly urge the agencies to prioritize achieving regulatory compliance through physician education and amelioration, including implementation of a CAP process, instead of leading with deterrence through immediately levied disincentives**.

If HHS, CMS, and ONC are unable to implement a CAP process as outlined above, the AAFP strongly urges the agencies to delay implementation of these regulations by a minimum of one calendar year from when the final regulation is published. While we appreciate and have joined ONC and other stakeholders in undertaking significant educational efforts to make health care practitioners aware of information blocking regulations, many physician practices remain unaware or ill-prepared for enforcement. **The AAFP urges the development of an intra-agency communications plan and educational outreach program specifically designed to reach physicians in underserved communities and small practices**. Both a remediation process as outlined above or a year's delay in enforcement would provide the agencies with time to create and administer a robust communications and educational strategy. The AAFP stands ready to partner with CMS, ONC, and HHS in developing and executing a strategy that will reach those practices most in need of help.

In addition to the proposed CAP process outlined above, the AAFP urges the agencies to implement an appeals process that would allow physicians to formally object to an initial determination of information blocking or issued disincentive. Given that physician practices rely on their EHR, patient portal, and other vendors to provide and maintain updated technology to transmit and receive health data, there may be instances where information blocking results from a technological failure that the physician is unaware of and/or cannot control. Thus, there should be an established, clearly defined appeals process that offers the opportunity for clinicians who believe they have been incorrectly found guilty of information blocking or incorrectly issued a disincentive to object to OIG's determination. This would be similar to the appeals process discussed in the MSSP section of this proposed rule.

Once regulations are finalized, the AAFP urges ONC to work with CMS and HHS to develop a suite of educational resources designed specifically for small and independent physician practices, many of which are still unaware or underinformed of information blocking requirements. For optimal clinician usability, developed resources should be concise and actionable, outlining the insights, steps, and actions practices need to take to ensure they are fulfilling information blocking requirements. **We strongly encourage ONC and CMS to engage physicians in solo and independent practices in the resource development process to ensure their educational and operational needs are fully met**. Physicians continue to report confusion with provisions of the information blocking regulations, including on the appropriate application and documentation of information blocking exceptions, what OIG considers an "unreasonable practice" when evaluating for information blocking, and the parameters governing "actual knowledge" as an expected enforcement priority. Family physicians want and need best practices and implementation guides that they can reference as they strive to understand and comply with these regulations. Without real-world guidance, clinicians will continue to struggle with implementing internal policies to avoid allegations of information blocking.

Definitions of Appropriate Agency and Appropriate Disincentives

ONC, CMS, and HHS propose to define the term "appropriate agency" as a federal agency that has established disincentives for health care practitioners that OIG finds guilty of information blocking. The agencies propose to define "disincentive" as "a condition that may be imposed by an appropriate agency" on a clinician or entity OIG finds guilty of information blocking. The agencies consider "appropriate" disincentives to be any condition established through rulemaking that is believed would

deter information blocking practices. The disincentives provision does not propose a limit on the number of disincentives an agency can impose on a clinician, and the agencies believe that cumulative disincentives, where applicable, would provide further deterrence.

The AAFP does not object to the agencies' proposed definitions of "appropriate agency," "disincentive," or "appropriate" disincentives. However, we are concerned that allowing unlimited cumulative disincentives without defined exceptions could negatively and disproportionately impact the smallest and least resourced physician practices. These practices are least likely to be aware of information blocking regulations and least likely to have significant time or money to invest in compliance. The AAFP strongly supports OIG notifying clinicians of information blocking investigations as early into the process as possible, particularly in cases where a physician is being investigated for multiple claims of a single type of information blocking. Most instances of information blocking are not malicious or intentional, and we do not want physicians found guilty of accidental information blocking to be cumulatively penalized without first being given an opportunity to ameliorate the violation.[1] **The AAFP reiterates our strong support for implementation of a CAP process, including remediation procedures physicians can use to resolve instances of information blocking prior to any disincentives being applied**.

OIG Investigation and Referral

While this section did not contain regulatory proposals, OIG outlined and invited comments on its anticipated enforcement priorities for clinicians and health IT vendors. OIG clarified that the legal standard of intent for health care practitioners differs from the legal standard of intent for health IT developers. The agency stated that "actual knowledge" is not expected to be an enforcement priority when investigating allegations of physician information blocking. OIG emphasized that each allegation of information blocking is unique and will be evaluated accordingly; the agency also said it would coordinate with other HHS agencies to avoid duplicate penalties.

The AAFP encourages OIG to add an anticipated enforcement priority regarding intentional or "actual knowledge" instances of clinician information blocking. While we appreciate that the legal standard of intent differs between practitioners and health IT vendors, we also know that many instances of information blocking are unintentional. If this was included as an enforcement priority, tracking and analyzing instances of intentional information blocking would be much simpler. This would also allow agency staff to more easily identify patterns in cases of unintentional information blocking and target educational outreach where it's shown to be most needed.

Though the AAFP understands OIG cannot apply a specific formula to every allegation of information blocking, **we continue to strongly urge OIG, ONC, CMS, and HHS to offer physicians guidance, clarity, and resources that provide examples of information blocking that would be subject to a disincentive**. Family physicians need best practices and implementation guides they can reference as they work to understand these regulations and adjust their workflows. Without real-world guidance, clinicians will continue to struggle with implementing the internal policies necessary to avoid allegations of information blocking. Additionally, the AAFP urges the agencies to specify what plans and processes are under development or currently implemented to ensure physicians will not be subject to erroneous duplicative penalties. Providing clarity in this area would support our shared values of accountability and transparency, as well as offering assurance to clinicians.

General Provisions for Application of Disincentives

HHS, CMS, and ONC outline the proposal's major components, detail the information that would be shared with a clinician found guilty of information blocking, and clarify that notification of multiple disincentive penalties could be included in a single communication with the health care practitioner. The agencies state that a physician may have the right to appeal a disincentive penalty, depending on if the authority used to establish the disincentive allows for administrative appeals. It's noted that

the Cures Act did not issue instructions regarding practitioner appeals of disincentives, though an appeals process was authorized for health IT developers who are found guilty of information blocking.

The AAFP appreciates this summary of the proposed rule's provisions, and we discuss each of the key proposals of the rule in detail further in this letter. **The AAFP is concerned that the disincentives framework outlined in this proposed rule will disproportionately penalize independent, small, rural, and other under-resourced practices, particularly because of the all-or-nothing approach taken to clinician disincentives, regardless of whether information blocking was intentional or whether the actor has taken steps to address outstanding issues. As detailed further below, we strongly urge the agencies not to finalize the proposed disincentives for clinicians and practices in MIPS and MSSP.**

While the AAFP understands that the Cures Act did not specifically outline an appeals process for health care practitioners found guilty of information blocking as was done for health IT developers and health information networks and exchanges (HINs/HIEs), we strongly believe it is within CMS' authority to establish both a CAP and an appeals process for physicians found guilty by OIG of information blocking, as has been done in several other CMS programs. **We urge the agencies to implement a CAP process, including remediation procedures through which physicians can resolve information blocking issues and avoid being issued a disincentive**.

<u>Transparency for Information Blocking Determinations, Disincentives, and Penalties</u>
The AAFP agrees with HHS, ONC, and CMS that it is important to promote transparency about how and where information blocking is impacting the nationwide health IT infrastructure. If a health care practitioner was found guilty of information blocking, the agencies propose to publish on ONC's website the clinician's name, business address, instance of information blocking, the disincentive applied, and where to find additional publicly available information. This information would not be published online until after the disincentive had been imposed. Physicians eligible for a separate right to review information under their Medicare program—such as MIPS eligible clinicians having a right to review their performance information prior to it being made publicly available—would retain that right and be able to review the information about their applied disincentive before it could be published on ONC's website.

We support the agencies' proposal to publish relevant information on ONC's website about health care practitioners and health IT vendors found guilty of information blocking **only if the agencies either implement a CAP process as described in detail above in this letter or delay implementation of these regulations by a minimum of one calendar year from when the final regulation is published**. Physicians need additional time to understand these and other information blocking regulations, and they should be given the opportunity for remediation before being publicly reported for information blocking.

The AAFP strongly supports alignment between this proposed rule and the existing rights physicians have under their Medicare programs. We support the proposal to maintain eligible clinicians' right to review performance information, including being able to review their applied disincentives for information blocking violations prior to that information being published on ONC's website.

The proposed rule refers to the more than 800 claims of information blocking that have been submitted via the Report Information Blocking Portal between April 5, 2021, and September 30, 2023. While OIG has clarified previously that health IT vendors will start being evaluated for claims of information blocking occurring on or after September 1, 2023, clarity is not offered on whether OIG intends to evaluate claims of information blocking levied against a health care practitioner prior to disincentives being finalized. **The AAFP requests OIG answer definitively whether they intend to**

evaluate the claims submitted during the above dates for information blocking violations, and we recommend against issuing disincentives for information blocking claims made before this rule is finalized.

The AAFP agrees with the agencies that ONC should publicly provide data and related insights into how and where information blocking conduct is occurring and how it is impacting the broader nationwide health IT infrastructure in real time. Once regulations go into effect, we propose the agencies work collectively to closely measure, analyze, and publicly publish data on ONC's website regarding the application and deterrence effects of clinician and health IT vendor disincentives. **The AAFP strongly supports the agencies' shared principles of transparency and accountability, and we therefore encourage the agencies to promptly evaluate and publicly share analysis on whether these regulations are succeeding in meaningfully disincentivizing information blocking**.

Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs)

Within the Medicare Promoting Interoperability Program, eligible hospitals and CAHs are considered meaningful EHR users for a given reporting period if they demonstrate 1) certified EHR technology (CEHRT) was used in a meaningful manner, and 2) the CEHRT is appropriately connected to successfully exchange electronic health information in accordance with the law. If eligible hospitals fail to meet these requirements, CMS will reduce the hospital's payment by three-quarters of the applicable percentage increase in the annual rate-of-increase for hospitals. For CAHs, CMS will pay the hospital 100 percent of its reasonable costs instead of 101 percent. The agencies propose here to use these same penalties for eligible hospitals and CAHs that are found guilty of information blocking, stating that acts of information blocking would significantly undermine these requirements.

CMS proposes to apply a disincentive for information blocking to the payment adjustment year related to the calendar year in which OIG refers its findings to CMS. The agency notes that if an eligible hospital or CAH was found to not be a meaningful EHR user in the Promoting Interoperability Program, they would not be double-penalized for also information blocking, even if found guilty. CMS further clarifies that even if numerous instances of information blocking are shared by OIG in a single referral, including violations over multiple years, the disincentive would only impact an eligible hospital or CAH's status for a single year's reporting period.

The AAFP agrees that acts of information blocking would frustrate and undermine the Promoting Interoperability Program's requirements for meaningful EHR users, and we understand the agencies' reasons for proposing this disincentive. The AAFP urges the agencies to monitor whether these disincentives sufficiently deter information blocking by hospitals. Other penalties for hospital non-compliance of federal regulations have had to be strengthened to more effectively outweigh the competitive advantage of noncompliant behavior. Hospitals and health systems are significant sources of patient health data, particularly given recent consolidation in the health care market. Thus, it is important that these disincentives drive compliance by these actors. The AAFP strongly urges the agencies to consider how the proposals in this and other sections do or do not promote equity in terms of the disincentives' likely financial impact on various types of health care practitioners.

Promoting Interoperability Performance Category of MIPS

CMS proposes that a MIPS eligible clinician (EC) who has been determined to have committed information blocking at any time during the calendar year performance period would not be a meaningful EHR user. CMS further proposes that the EC would not earn a score in the promoting interoperability performance category. The disincentive would be applied to the MIPS payment year associated with the calendar year in which OIG referred its determination to CMS. CMS also

proposes that the application of the disincentive would be applied at the same level data is submitted (e.g., individual, group, virtual group).

The AAFP opposes the all-or-nothing approach to this proposal and instead urges CMS to pursue a scaled MIPS disincentive that takes into account relevant factors, as proposed in the alternative approach for MSSP. The AAFP is concerned that this policy would prevent ECs from earning a positive payment adjustment under MIPS, particularly those who fulfilled all other requirements to demonstrate meaningful use. The performance threshold for the 2024 performance year is 75 points, which means an EC who is subject to this disincentive would, at minimum, receive a neutral payment adjustment. The performance threshold is expected to increase, meaning this proposal would guarantee an EC receives a negative payment adjustment in the future.

We are concerned that applying disincentives without first providing an opportunity to correct the issue would cause financial harm to practices, reduce the resources they have available to develop robust information sharing capabilities, and disincentivize quality reporting and improvement efforts. Further, as we noted in our comments on the calendar year 2024 Medicare Physician Fee Schedule and Quality Payment Program proposed rule, this proposal will contribute to an already-flawed MIPS program that results in greater financial penalties for small, medium, and rural practices that are used to paying for positive payment adjustments for large health systems and payer-owned practices. We believe this will be particularly detrimental to independent practices who, as noted elsewhere in our comments, will likely lack the resources required to ensure they do not commit information blocking.

The AAFP is also concerned with the proposal to apply the disincentive at the group or virtual group level. The majority of ECs participate in MIPS as a group, and this may dissuade group participation. Should CMS move forward with applying disincentives, we ask that CMS revise its policy and apply a neutral payment adjustment only to the national provider identifier(s) (NPIs) who committed information blocking, rather than penalizing the entire group or virtual group.

<u>MSSP</u>
CMS proposes that a clinician that commits information blocking may not participate in the Shared Savings Program (SSP) for a period of at least one year. CMS proposes to include a specific reference to the Cures Act's information blocking regulations and require compliance as a condition of participation in the MSSP. CMS proposes to screen "ACOs, ACO participants, and ACO providers/suppliers" for an OIG determination of information blocking and deny the addition of such a health care practitioner to an ACO's participation list for a period of at least one year. In instances where the ACO is a health care practitioner, CMS would deny the ACO's SSP application for at least one year. When the program integrity screening identifies that an ACO clinician has committed information blocking, CMS would deny the request of the ACO to add an ACO participant to the participant list, notify an ACO if one of its ACO participants or ACO clinicians has committed information blocking so the ACO can take remedial action, deny the ACO's MSSP application if the screening reveals a history of program integrity issues or other sanctions, and terminate an ACO participation agreement in the case of a failure to comply with the requirements of the SSP.

CMS proposes to apply the disincentive no sooner than the first performance year after they receive a referral of information blocking. In the case of the new addition of an ACO participant (TIN) to an ACO's participant list, CMS would prevent the TIN from joining the ACO. CMS believes applying the disincentive proactively is the most appropriate timing, and it would be impracticable and inequitable for CMS to apply the disincentive retroactively or in the same year in which CMS received the referral from OIG.

After one year, the ACO may submit a change request to add the TIN or include the NPI on its ACO participant list. CMS would approve the request so long as the OIG has not made any additional determinations of information blocking, the ACO provides assurances that the information blocking is no longer occurring, and the ACO has put safeguards in place to prevent the information blocking that was the subject of the referral.

CMS is considering an alternative policy where they would not apply the disincentive in certain circumstances. CMS would consider a referral in light of the relevant facts and circumstances before denying the addition of an ACO participant, informing an ACO that remedial action should be taken, or denying an ACO's application. Relevant facts and circumstances could include the nature of the clinician's information blocking, the practitioner's diligence in identifying and correcting the problem, the time since the blocking occurred, the time since the OIG's determination, and other factors.

If it is not prohibited by regulation, an ACO may be able to appeal an initial determination of information blocking, the removal or denial of a clinician from an ACO participant list, the denial of the ACO's application, or termination of the ACO's participation agreement. The underlying information blocking determination made by OIG would not be subject to SSP reconsideration, as it is not made by CMS.

The AAFP strongly opposes the proposal to remove clinicians, practices, and ACOs from the MSSP program. We appreciate that the alternative proposal provides more flexibility than a one-size-fits-all approach that is unnecessarily punitive and will certainly disrupt patient care. **Disincentives should take into account the severity and frequency of information blocking, and we encourage CMS to apply this approach to other clinicians.** Information blocking is often more nuanced and not always intentional or malicious, and the application of disincentives should not treat all situations as such. Physicians should not be penalized when they have already identified the issue and taken steps to remedy it, nor should they be punished for information blocking that took place several years in the past and is no longer an issue.

Perhaps more importantly, removing clinicians, practices, and/or ACOs from the MSSP program inappropriately passes these penalties down to the Medicare patients that are attributed to and benefit from their physicians' participation in an ACO. ACOs provide care coordination and care management services, invest in whole-person care, and ultimately improve patient outcomes while lowering health care spending. Barring participants from the MSSP program will prevent them from providing more advanced services, disrupting patients' care in the process. Therefore, the AAFP firmly opposes this proposed disincentive.

We note that CMS' proposed disincentives do not take into account key features of the MSSP program. Since the MSSP is a full-TIN program, it is unclear how an ACO would exclude a single NPI from its participant list. Instead, the ACO would be forced to exclude the entire TIN from participating with the ACO, which would be disruptive to all involved – the ACO, the physician practice, and the patients. We are concerned that an overly punitive approach will slow progress toward alternative payment models, including the MSSP. CMS should avoid policies that unnecessarily reduce ACO participation, since that is counter to the agency's own goals of moving more patients to accountable care relationships. Additionally, ACOs rely on data and information sharing to succeed, and the AAFP encourages CMS to view ACOs as partners who can assist the agencies in achieving their interoperability goals by proactively addressing information blocking activities, whether intended or inadvertent.

<u>Interaction of Disincentives between MIPS and ACOs</u>
The AAFP is concerned about how disincentives would be applied to physicians who are in both the MSSP and MIPS and found to be guilty of information blocking, since some physicians in MSSP

ACOs also report to the MIPS program. It is unclear how these disincentives would interact, and we are concerned that layering disincentives could disproportionately impact small practices. The AAFP strongly opposes an approach that would penalize physicians under both programs for the same information blocking finding. The agencies should clarify in the final rule under which program the disincentive would be applied.

Request for Information

The agencies request public comment on "additional appropriate disincentives" to be considered for future rulemaking, particularly for the wide range of health care practitioners who are subject to information blocking requirements but are not subject to this proposed rule. The agencies encourage comments on which practitioners should be prioritized for establishing future disincentives.

The AAFP agrees with the agencies that it is important for HHS to establish disincentives for every type of health care practitioner who is subject to information blocking regulations. As the agencies work to develop additional disincentives for other types of practitioners, **we urge 1) implementation of a single CAP process for all health care practitioners, including remediation procedures through which information blocking issues can be resolved without a disincentive being issued; and 2) not removing physicians from value-based care arrangements as a penalty for information blocking**. The practice of removing clinicians from these arrangements directly contradicts CMS' stated goal of having all practices in an accountable care relationship by 2030. The AAFP looks forward to continued collaboration with the agencies to support the expansion of value-based care nationwide, and we would welcome the opportunity to help identify appropriate disincentives for physicians found guilty of information blocking.

The AAFP appreciates the collective efforts of CMS, ONC, and HHS to improve clinicians' understanding of current information blocking requirements by defining and outlining proposed disincentives for the health care practitioner community. We support the goals and intent of these proposals, and we appreciate the opportunity to comment on areas of the proposed rule that we believe require additional clarity and potential alternatives. The AAFP looks forward to continued partnership with ONC, CMS, and HHS to advance appropriate and clear information blocking regulations that will reduce clinician administrative burdens and improve patients' access to their health data. Please contact Mandi Neff, Regulatory and Policy Strategist, at mneff2@aafp.org with any questions or concerns.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair