



June 3, 2019

Alex M. Azar II, Secretary
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Mary E. Switzer Building
Mail Stop: 7033A
330 C Street SW
Washington, DC 20201

Dear Secretary Azar:

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write in response to the Interoperability and Patient Access [proposed rule](#) as published by the Office of the Secretary in the March 4, 2019, *Federal Register*.

The AAFP applauds the Administration's continued push toward a nationwide interoperable health care system. Family physicians routinely struggle with acquiring the right health information to make the best decisions with their patients. The lack of interoperability is a fundamental issue leading to increased cost, burden, and frustration as well as lowering quality and health. We applaud the Administration's effort to drive adoption of Application Programming Interfaces (APIs) and trusted exchange within the health plan community.

The AAFP strongly supports the move toward open APIs and standards-based APIs. We agree with adding the requirement for health plans to deploy API access to patients. We also believe these APIs should be made available for physicians and other health care providers such that they can also have ready access to these needed data. These data would help support continuity of care, care coordination, and enable better cost-effective care. One area of concern though is in the requirement to make these data available in one business day and the recommendation for health plans to amend contracts with physicians and other health care providers to require near real-time data submission. We are concerned that this will increase the administrative burden on physicians, especially since the usability of EHRs and requirements from CMS make it difficult to complete documentation in a timely manner. We oppose this mandate and ask that CMS remove the requirement that physicians and other health care providers submit claims and encounter data in near real-time.

Regarding the strong push toward APIs and eliminating information blocking, we are concerned that commenters may push HHS for unfettered access to physician EHRs by payers. We strongly oppose such access, as the physician and patient may have data within the EHR that the patient does not want to share with the payer. Such access may also lead to selective, discriminatory reimbursement models and intrude on physician medical decision-making.

STRONG MEDICINE FOR AMERICA

President John Cullen, MD Valdez, AK	President-elect Gary LeRoy, MD Dayton, OH	Board Chair Michael Munger, MD Overland Park, KS	Directors Robert Raspa, MD, Orange Park, FL Leonard Reeves, MD, Rome, GA Ada Stewart, MD, Columbia, SC	James Ellzy, MD, Washington, DC Dennis Gingrich, MD, Hershey, PA Tochi Iroku-Malize, MD, Bay Shore, NY
Speaker Alan Schwartzstein, MD Oregon, WI	Vice Speaker Russell Kohl, MD Stilwell, KS	Executive Vice President Douglas E. Henley, MD Leawood, KS	Sterling Ransone, MD, Deltaville, VA Windel Stracener, MD, Richmond, IN Erica Swegler MD, Austin, TX	LaTasha Selby Perkins, MD (New Physician Member), Arlington, VA Michelle Byrne, MD (Resident Member), Chicago, IL Chandler Stisher (Student Member), Brownsboro, AL

The AAFP strongly supports the exchange of timely Admission, Discharge, and Transfer (ADT) information to a patient's primary care physician or medical home. We greatly appreciate CMS' push to make these transactions routine by hospitals. However, we believe that the Conditions of Participation (CoP) represents a powerful policy hammer that should be used extremely judiciously and are concerned that if CMS finalized the requirement to support ADT exchange as a condition of participation:

1. Some beneficiaries will see increased access to care issues as some hospitals, likely smaller and more rural hospitals, may not be able to comply and
2. Given the current state of infrastructure and standardization in this area, the implementation by many of the hospitals will not have good usability for physicians.

For these reasons, we ask CMS to reconsider including ADT exchange as a CoP and instead identify incentive-based policy levers to drive adoption of ADT exchange. As the infrastructure matures, HHS could then reconsider inclusion of CoP.

To accelerate the adoption of nation-wide interoperability, appropriate digital contact information for hospitals, practices, and clinicians must be available. The AAFP supports the inclusion of digital contact information within the National Provider and Plan Enumeration System (NPPES) but have some concerns. This system has data quality issues and houses outdated information. To address these issues, the AAFP recommends CMS centralize the collection and storage of physician and other health provider contact data. The NPPES, Provider Enrollment, Chain, and Ownership System (PECOS), and other federal systems should be consolidated into a single system for these data. Additionally, CMS should work with state and private entities to establish APIs that would allow for a single point for a physician to update their information and allow these data to extend to all appropriate state and federal entities.

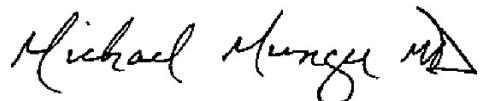
Regarding the reporting of eligible professionals that negatively attest to the prevention of information blocking under 42 CFR 414.1375(b)(3)(ii)(A) through (C), the AAFP supports public reporting of that fact for these individuals. We concur with CMS' proposal that a non-response is not a negative response to these attestations. It is important for CMS to be clear in its public reporting that a blank is not equivalent to a negative response and that there are often valid reasons for a blank response.

In the proposed rule, CMS outlines standards that must be adopted to support APIs and other health information exchange. CMS also notes that there is a process for allowing the use of updates to those standards. We strongly support requiring the use of standards and for allowing a non-rulemaking process to update them. We have concern with some language in section II(A)(3) stating HHS's intent to preclude the use of some content and vocabulary standards; we believe precluding the use of additional standards or other exchanges of information would not only stifle innovation but would halt it. The AAFP is pleased the proposed rule contravenes this statement. The AAFP opposes restricting regulated entities from sharing information in the manner they choose and adamantly supports requiring regulated entities to support a common, standards-based exchange platform. Should two or more regulated entities wish to use other, likely more robust, standards (or a non-standard approach) to exchange information, they should be able to do so but those entities must also provide the standard based approach mandated in regulation.

The navigation of state and federal privacy rules continues to be a large challenge for the health care system. The notice of proposed rulemaking on information blocking highlighted the complexity and burdens on physicians to navigate within this inconsistent patchwork. This rule highlights that challenge for health plans. As we commented in the information blocking rule, HHS should establish a process to pre-arbitrate these state and multiple federal laws and provide clear guidance for the health care system. We believe the work required in section III(C)(2)(h) of this proposed rule, which requires health plans to provide clear guidance to beneficiaries, is really the role of HHS. We also believe the requirement to educate beneficiaries on the appropriate terms for third-party applications (to connect to API from health plans and providers) is also a role for HHS and the Federal Trade Commission.

We appreciate the opportunity to provide these comments. Please contact Steven E. Waldren, MD, MS, Vice President and Chief Medical Informatics Officer, at 913-906-6165 or swaldren@aafp.org with any questions or concerns.

Sincerely,



Michael L. Munger, MD, FAAFP
Board Chair

About Family Medicine

Family physicians conduct approximately one in five of the total medical office visits in the United States per year—more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families, and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.