March 14, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Verma,

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the recently announced MyHealthEData initiative, which is designed to empower patients through greater control and portability of their healthcare data. The AAFP is very pleased to see agency efforts that encourage patients to have meaningful control of their data, and we likewise strongly support the improved interoperability of this information between physicians and healthcare delivery systems. We also appreciate other administrative simplification and modernization objectives and efforts announced by the agency. We would, however, object to placing responsibility for the adoption of interoperable systems on physician practices. The creation of standardized interoperable systems should instead be the responsibility of vendors.

MyHealthEData and Medicare's Blue Button 2.0

The AAFP supports improving patients' access to healthcare data and agrees with the agency that data security is of the utmost importance. To achieve improved, secure patient access, actual interoperability of electronic health care records is first required, something practicing physicians were promised when they purchased and updated their systems to Certified Electronic Health Record Technology (CEHRT). Nevertheless, many systems do not meet this standard. Due to the lack of such interoperability, physicians are currently and unfortunately beholden to their electronic health record (EHR) vendors. This has resulted in vendors possessing a monopoly within the practice and the vendor's ability to price gouge the practice for software upgrades and maintenance. **To realize meaningful patient access to their data, we strongly urge CMS to require EHR vendors to provide any new government-required updates to such systems without additional cost to the medical practice.**

EHRs must work better. Multiple studies cited in a recent AAFP letter to the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) conclude that family physicians spend nearly one-half of their workday interacting with EHRs during and after clinic hours. Despite the laudable intent of underlying health care policies, the burden on the practicing physician, in terms of time and practice costs, has expanded to an untenable level. CMS must take the time and financial costs physicians endure into account while addressing improved patient access to healthcare data.

Streamlining the Meaningful Use and QPP's Advancing Care Information requirements

While the AAFP recognizes that CMS significantly reduced reliance on measures using an EHR in the Merit-based Incentive Payment System's (MIPS) Advancing Care Information (ACI) component as compared to the Meaningful Use (MU) program, further significant efforts are still needed. **Now that MIPS utilizes measures of quality, cost, and practice improvement, the AAFP calls for all HIT utilization measures to be eliminated.** Because we recognize that some of these uses are mandated in statute, we urge CMS to work with Congress to remedy this unfortunate and outdated approach. The AAFP recently published a study that provides a prioritization for the most burdensome components of the EHR that have been part of utilization measures. EHR rules should be modified based on that study. Principles to achieve decreased burden include:

- Policies that mandate (or financially penalize) physicians' prescribed use of HIT should be analyzed to assess the evidence of benefit and burden in real-world practice prior to implementation.
- Policies that support the varying needs of the diverse populations for whom physicians provide care. A generic, one-size-fits-all model, will lead to further system waste.

Interoperable quality measures

We appreciate that CMS is drafting uniform standards required under the *21st Century Cures Act* to aid interoperability between different EHR programs, and we look forward to providing further comments on the draft uniform standards. As articulated, the AAFP calls for all HIT utilization measures to be eliminated. **All payers (public and private) should implement the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure efficiency, alignment, harmonization, and the avoidance of competing quality measures.**

Ending Information Blocking

Family physicians receive "summaries of care" (and other Consolidation-Clinical Document Architecture documents) that are unnecessarily long and filled with clinically irrelevant information. Because family physicians must wade through this documentation to find clinically relevant information, physician time is wasted and cognitively burdensome. Many times, unneeded information is placed in summaries of care by automated processes, which are designed to ensure compliance with CMS regulations and requirements for the MU and ACI programs. **The AAFP calls on CMS to reform regulatory requirements to focus instead on how and when data is exchanged rather than focusing on the data in the exchange. The AAFP calls on CMS to fully use its Information Blocking authority granted in *21st Century Cures* to penalize those healthcare organizations not appropriately sharing information.** We would urge CMS to improve usability and then focus on interoperability. AAFP principles to end information blocking include:

- Policies should be focused on ensuring standards-based capabilities are in place for information exchange.
- Policies should be focused on "pulling" interoperability by aligning financial incentives, such that interoperability is good business.
- Policies should be focused on penalizing bad actors blocking information.

Patient access to discharge data

Communication and EHR interoperability barriers continue to hinder the uptake of transitional care management services. The stringent and brief time frames for patient contact after hospital discharge in combination with the lack of open communication between hospitals and primary care physicians impedes family physicians' ability to provide these important services. Enhanced EHR and HIE (health information exchange) would reduce the burden on both physicians and hospitals and provide for reduced patient readmissions. These activities would, in turn, result in reduced cost for government payers, physicians, hospitals, health plans, and consumers. **CMS should work with ONC and the Office of the Inspector General to ensure wide-scale interoperability of admission, discharge, and transfer (ADT) data in near real-time, so physicians can spend their limited time on managing patients' follow-up care instead of trying to discern which patients were seen by whom and when care was provided. .**

Streamlined documentation and billing requirements

Despite the adoption of EHRs, documentation requirements for public and private payer programs and initiatives have escalated. In particular, the CMS Documentation Guidelines for Evaluation and Management (E/M) Services, established 20 years ago, do little to support patient care. Instead, they are often used more to justify billing levels (e.g. level 3, 4, or 5) than to help physicians diagnose, manage, and treat patients. Adherence to E/M Documentation Guidelines consumes a significant amount of physician time and does not reflect the workflow of primary care physicians. These guidelines were drafted for use with paper-based medical records and do not reflect the current use and further potential use of EHRs or team-based care. They also negatively impact the usability of EHR software programs. In our study of MU criteria, electronic documentation of the patient encounter was the most burdensome task. Guidelines also hinder interoperability by requiring the capture of clinically irrelevant information that is subsequently exchanged. AAFP principles to reduce documentation requirements include:

- **As part of the Medicare Quality Payment Program, documentation guidelines for E/M codes 99211-99215 and 99201-99205 should be eliminated for primary care physicians.**
- **Outdated E/M documentation guidelines and the Medicare Program Integrity Manual should be changed to allow medical information to be entered by any care team member related to a patient's visit. This standard should be applied by all Medicare contractors, Medicaid, marketplace policies, and private payers.**
- **The primary purpose of medical record documentation should be to record essential elements of the patient encounter and communicate that information to other providers. The use of templated data and box-checking should be viewed as administrative work that does not contribute to the care and wellbeing of the patient.**
- **EHR vendors, physicians, and workflow engineers must collaborate to redesign and optimize EHR systems.**

Addressing duplicative testing

Without a strong primary care foundation, the fragmentation, duplication, and unnecessary costs that have plagued America's health care system will continue despite efforts to

increase quality of care. As payment models evolve from fee-for-service, the AAFP believes advanced alternative payment models and other measures of utilization of services can help improve patient care and costs, such as reduced admissions and readmissions and reductions in duplicative or clinically unnecessary testing. In the long term, advanced primary care practices with enough patients and well-developed care coordination and management capabilities should be able to demonstrate impact on total cost of care. This is the goal for the AAFP's Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) along with working in concert with the development of other specialty or condition-specific models, where appropriate.

Thank you very much again for the development of MyHealthEData and Medicare's Blue Button 2.0. With the modifications we have suggested and attention to other overarching HIT issues as outlined above, we believe these programs will lead to great success for our patients by catalyzing better, more efficient, quality care. We stand ready to assist in your efforts. Should you have questions, please contact Dr. Steven Waldren, Director of the AAFP's Alliance for eHealth Innovation, at 913-906-6000 ext. 4100 or swaldren@aafp.org.

Sincerely,

John Meigs, Jr., 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.