February 7, 2018

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

Don Rucker, M.D., National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St SW, Floor 7
Washington, DC 20201

RE: AAFP recommendations to reduce clinician burden from health information technology

Dear Administrator Verma and Dr. Rucker,

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write to express our appreciation for the opportunity to participate in the recent Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) joint meeting on reducing clinician burden as part of the Patients over Paperwork initiative. We look forward to participating in the subsequent February 22, 2018, meeting on this important subject.

The AAFP maintains that the current regulatory framework with which primary care physicians must comply is daunting and often demoralizing. Standardization is not required among public or private payers, and many family physicians participate with 10 or more payers. Physicians are forced to navigate rules and forms for each payer. As a result, physicians spend needless hours reviewing documents and literally checking boxes to meet the requirements of each health insurance plan. This is time that physicians could better spend caring for patients.

A retrospective study involving 142 family physicians, over a three-year period from 2013 to 2016, concluded that primary care physicians spend nearly 6 hours daily, or nearly one-half of their workday, interacting with electronic health records (EHR) during and after clinic hours. Similarly, a 2016 time and motion study of the allocation of physician time in ambulatory practice across four medical specialties in four states found, “physicians from family medicine, internal medicine, cardiology, and orthopedics spent nearly 2 hours in the EHR and on other desk work for every 1 hour of direct patient care.” In addition to the time burden, 2016 and 2018 studies show that family physicians and other physician experience high cognitive load while working with the EHR.

It is unfortunate and avoidable that the regulatory framework for physician practices has reduced face-to-face time with patients and increased operating costs at a time when physician payment is stagnant. The Medicare conversion factor has changed little over time. Crushing administrative and regulatory burden is one of the top reasons independent practices close and a leading cause of physician burnout. Despite the good intent of underlying health care policies, the burden on the practicing physician has expanded to an untenable level and is a significant barrier to achieving the Quadruple Aim of enhancing patient experience, improving population health, reducing costs, and improving the work life of clinicians and staff.

The AAFP has developed consensus principles on administrative simplification. Adherence to these principles will help ensure patients have timely access to treatment while reducing administrative burden on physicians. We encourage CMS and ONC to adopt policies and practices consistent with these principles to alleviate unneeded regulatory burdens and to improve patient care.

Minimize Health IT Utilization Measures

MACRA's Advancing Care Information (ACI) significantly reduced reliance on measures using an electronic health record (EHR) compared to Meaningful Use (MU). However, inefficient uses of health information technology (HIT) are still required under ACI in the Merit-based Incentive Payment System (MIPS). 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 and ONC 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 which have been part of utilization measures. EHR rules should be modified based on that study.

Principles:

- Policies that mandate (or financially penalize) physicians' prescribed use of health IT should be analyzed to assess the evidence of benefit and burden in real-world practice prior to their implementation.
- Policies should support the varying needs of the diverse populations for which physicians care and not establish a generic, one-size-fits-all model, as it leads to system waste.

Medical Record Documentation

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 serve more as a crutch 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. The guidelines negatively impact the usability of EHR software programs. In our study of the 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.

Principles:

- 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.

<u>Focus Interoperability Policy on Information Blocking and How Data is to be Exchanged</u>
Family physicians receive “summaries of care” (and other Consolidation-Clinical Document Architecture documents) that are filled with clinically irrelevant information and are unnecessarily long. Because family physicians must wade through this documentation to find clinically relevant information, physician time becomes more unproductive and cognitively burdensome. Many times, unneeded information is placed in the documents 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 and ONC 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 and ONC to fully use its Information Blocking authority granted in *21st Century Cures* to penalize those healthcare organizations not appropriately sharing information. We believe the priority relative to health IT is to improve usability and then focus on interoperability.

Principles:

- 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 that are information blocking.

<u>Lack of Standard Representation of Clinical Data Models</u>
We have not yet created a process to develop nationally recognized and consistent data models that can be used across the healthcare ecosystem. The AAFP is actively working on achieving this interoperability standardization through participation in the American Medical Association’s Integrated Health Model Initiative and the Clinical Information Interoperability Council (CIIC). Nationally implemented, consistent data models are fundamental to smart HIT, which has the potential to dramatically reduce administrative and clinical physician burden.

Principles:

- The creation of consistent data models should be led by physicians and other clinicians, not policymakers, vendors, or engineers.

- Funding and support for the creation of consistent data models should be made available by the federal government.

Prior Authorization

Physicians strive to deliver high-quality medical care in an efficient manner. The frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior authorizations (PAs) from prescription drug plans, durable medical equipment (DME) suppliers, and others impede this effort.

Principles:

- Activities requiring PA must be justified in terms of financial recovery, cost of administration, workflow burden, and lack of another feasible method of utilization control.
- Rules and criteria for PA determination must be transparent and available to the prescribing physician at the point of care. If a service or medication is denied, the reviewing entity should provide the physician with the reasons for denial. For medications, it should provide alternative choices.
- PA should be eliminated for physicians with aligned financial incentives (e.g. shared savings, etc.) and proven successful stewardship.
- There should be a goal of eliminating PA for DME, imaging, supplies, and generic drugs.

Transitional steps include:

- Limiting and reducing the number of products and services requiring PA
- Adopting a standardized form and process for PA among all payers
- Requiring payers and pharmacy benefit managers (PBMs) that design PA specifically to save the payer or PBM money rather than benefit the patient to pay physicians for their time, as decided by the 2008 *Merck-Medco v. Gibson* court case
- Requiring payers to pay physicians for PAs that exceed a specified number or are not resolved within a set time-period
- Prohibiting payers from requiring repeated PAs for effective medication management for patients with chronic disease and PA for standard and inexpensive drugs.

Quality Measures and the Need for Measure Harmonization

In the past 15 years, quality measures have proliferated, leading to a significant compliance burden for physicians. Most of the measures are disease-specific process measures, rather than more meaningful evidence-based outcomes measures. With many family physicians submitting claims to more than 10 payers, the adoption of a single set of quality measures across all public and private payers is critical.

Principles:

- Quality measures should be focused on improving processes and outcomes of care in terms that matter to patients.
- Quality measures should be based on best evidence and reflect variations in care consistent with appropriate professional judgment.
- Quality measures should be practical, given variations of systems and resources available across practice settings.

- Quality measures should not separately evaluate cost of care from quality and appropriateness.
- Payers should consider the burden of data collection, particularly in the aggregation of multiple measures.
- Payers should provide transparency for methodology used to rate or rank physicians.
- All payers (public and private) should implement the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure parsimony, alignment, harmonization, and the avoidance of competing quality measures.
- Quality measure feedback reports should be simplified and standardized across all payers to make them more actionable.
- Quality measures should be updated regularly or when new evidence is developed.
- As new quality measures are introduced, measure developers and endorsers should reconcile or sunset related measures, so that only the most robust measures remain.
- Physicians should not be accountable for quality measures over which they do not have control or authority to improve.

Certification and Documentation

Physicians want to efficiently order what patients need to manage disease conditions in a way that maintains patient health. The current procedures surrounding coverage of medical supplies and services impede this goal and add no discernible value to the care of patients.

Principles:

- The physician's order should be sufficient. Physicians should not have to sign multiple forms from various outside entities for patients to receive needed physical therapy, home health, hospice, or DME, including diabetic supplies.
- Physicians should not be required to recertify DME supplies annually for patients with chronic conditions.
- Authorization for supplies should be generic, so physicians are not required to fill out a new form every time a patient switches brands, including but not limited to diabetic supplies.
- Authorization forms should be universal across payers. Data within the forms should be standardized to allow for automated EHR extraction and population of forms.
- Physicians should not be required to attest to the patient's status when the service is provided by another licensed health professional, as is the case with diabetic footwear.

Should you have questions, please contact Dr. Steven Waldren, Director of the 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.

CC:
Kate Goodrich, MD
Amanda Woodhead