AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

December 2, 2015

The Honorable Sylvia M. Burwell
Office of the Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS–3310 & 3311–FC

RE: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017

Dear Secretary Burwell:

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I am responding to the final rule with comment period, titled "Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017," published in the October 16, 2015 *Federal Register*.

The AAFP shares with HHS the goal of achieving successful practice and payment transformation that moves the health care system continually toward the three-part aim of improved health, better health care, and lower cost. Practice transformation is a time-intensive process that touches all aspects of a practice, including quality, safety, patient engagement, and population health management. However, we still have significant concern that this final rule does not allow for continued successful transformation toward the three-part aim, but rather places further obstacles in the path to this goal. During the duration of the Meaningful Use program the health care system has seen a 27-percent decrease in the satisfaction with electronic health records (EHRs).[1] According to the Centers for Medicare & Medicaid Services (CMS) own data, there has been a decrease in participation in the Meaningful Use program, with negative growth of 11 percent from 2013 to 2014.[2] This has caused a growing defection of early adopters out of the Meaningful Use program. Of those eligible professionals (EPs) that attested in either 2011 or 2012, only about 62 percent attested in 2014 and only 26 percent of those attesting to Stage 2.[3] These statistics and the palpable frustration in the EP community point to a program in crisis. The AAFP believes Stage 3 will only exacerbate this, even if the intent is to increase the requirements only marginally over Stage 2.

[1] AmericanEHR Partners. Physicians Use of EHR Systems 2014. http://www.americanehr.com/research/reports/Physicians-Use-of-EHR-Systems-2014.aspx
[2] Centers for Medicare and Medicaid Services. EP Recipient Payment File June 2015. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_ProvidersPaidByEHRProgram.zip
[3] Centers for Medicare and Medicaid Services. EP Recipient Payment File June 2015. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_ProvidersPaidByEHRProgram.zip

There is mixed evidence showing that Meaningful Use is moving us toward the three-part aim, with the evidence focused on health IT functionality and not on the Meaningful Use program.[4] The current certified EHR technology is not a good bridge to practice in a value-based payment environment.[5,6,7] Since 2010, the EHR vendor community has devoted the vast majority of its research and development resources to the acquisition of the needed components for Meaningful Use certification. The functionalities that are critical for value-based payment have been put on the back burner. Additionally, while we have seen progress on interoperability regarding continuity of care (i.e., transport of data), the health care system has not seen enough progress in care coordination (i.e., semantic exchange) interoperability, which is an essential capability of health IT for value-based payment and was part of Meaningful Use. EPs are still providing interoperability by viewing nationally selected standardized documents on their computer screens and then rekeying the information into the patient's discrete medical record. Given the current slow pace of work on interoperability, the AAFP remains deeply concerned that insufficient progress will be made by 2018 to allow providers to be successful in the value-based environment envisioned by the *Medicare Access and CHIP Reauthorization Act (MACRA)*.

Furthermore, the AAFP believes several barriers exist to meeting successfully the Merit-Based Incentive Payment System (MIPS) quality performance category that MACRA requires. The first and most significant barrier is the poorly designed Meaningful Use program and its lack of interoperability standards, which prohibit the sharing of patient information in a useful form.

Physicians face significant challenges with their EHRs and in meeting current Meaningful Use standards. Until the Meaningful Use program is improved and the EHR issues are resolved, it is difficult to foresee a large percentage of physicians—particularly physicians in small and independent practices—being successful in *MACRA* programs. EHRs should be a tool for success in a physician's practice, not an obstacle to overcome.

Since the health care system needs to transform practices and payment, the AAFP calls on HHS to transform the entire Meaningful Use program and not merely tweak the Stage 3 requirements.

The AAFP urges HHS to:

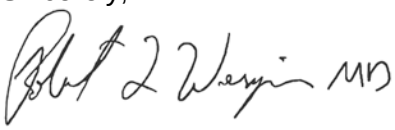
1. Pause the Meaningful Use program to:
    a. Allow the health care industry to focus on interoperability with the goal to accelerate work toward interoperable health IT supporting care coordination.
    b. Allow vendors and providers to focus on designing and implementing the functionality and workflows needed for the key capabilities for value-based payment. These include population based health management, care coordination through shared care planning, and the management of cost and quality.
    c. Allow for the regulations of Meaningful Use to be modified with the goal of complete alignment with pending *MACRA* regulations to maximize practices' efforts by reducing administrative and change burdens on practices.
2. Refocus and streamline Meaningful Use on interoperability and support capabilities needed for value-based payment. When the *Health Information Technology for Economic and Clinical Health Act*

[4] Jones SS et. al. Health Information Technology: An Updated Systematic Review With a Focus on Meaningful Use. Ann Intern Med. 2014;160:48-54.
[5] Bates DW, Bitton A. The future of health information technology in the patient-centered medical home. Health Affairs 2010 Apr;29(4):614-21.
[6] Fernandopulle R, Patel N. How the Electronic Health Record Did Not Measure Up to the Demands of Our Medical Home Practice. Health Affairs. 2010 Apr;29(4):622-28.
[7] O'Malley AS, et. al. Electronic Health Records and Support for Primary Care Teamwork. JAMIA 2015 Mar;22(2):426-34.

(HITECH), was signed into law, the intent was to promote the adoption and meaningful use of health information technology. When *HITECH* was passed, the medical community did not yet have the collection of policies levers made available in *Affordable Care Act* (*ACA)* and *MACRA*. Instead of piling everything in MU, CMS should rebalance the goals and requirements across all value-based programs since the goals of Meaningful Use may have better policy levers outside of Meaningful Use authority to encourage needed changes in the health care system. During this rebalance, requirements must be harmonized across the spectrum of regulations governing practice and payment transformation and health information technology.

The AAFP offers these recommendations in order to move the health care system toward achieving the three-part aim. Should you have questions, please contact Steven E. Waldren, MD, MS, Director, Alliance for eHealth Innovation at 1-800-274-2237, extension 4100 or swaldren@aafp.org.

Sincerely,



Robert L. Wergin, MD, FAAFP
Board Chair