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Submitted electronically

Donald Rucker, MD  
National Coordinator for Health Information Technology  
U.S. Department of Health and Human Services  
330 C Street, SW, Floor 7  
Washington, DC 20201

Re: Comments on the *Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*

Dear Dr. Rucker:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to comment on the Office of the National Coordinator for Health Information Technology's (ONC) draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs* (Strategy) designed to help reduce burden related to the use of health information technology (health IT) and electronic health records (EHRs). Because the report refers to HHS, ONC, and CMS, the AAMC's comments will be directed at each of these as appropriate.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 152 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Together, these institutions and individuals are the American academic medicine community.

The AAMC appreciates the Department of Health and Human Services (HHS) for its effort to address the undue burden that EHRs and other technology place upon health care providers and systems. Current systems in use, along with reporting and documentation requirements, have negatively impacted the practice of medicine. As referenced in the draft Strategy, "physicians and other health care providers, administrators, and institutions must comply with an ever-increasing, wide-ranging, and often poorly coordinated body of requirements to deliver, and receive payment for patient care."

The AAMC is an inaugural sponsor of the National Academy of Medicine’s (NAM) Action Collaborative on Clinician Well-Being and Resilience, a network of over 150 organizations committed to promoting clinician well-being across all career stages and specialties. The AAMC is committed to enhancing patient care and welfare, and to the belief that the optimal delivery of care requires an environment where all health care providers can thrive; where faculty, staff and learners feel supported and well treated; where diversity, inclusion and health equity are promoted; and where patients are empowered to make informed health care decisions. The NAM has published several papers regarding clinician documentation, electronic health records, and physician burnout, including “*Care-Centered Clinical Documentation in the Digital Environment: Solutions to Alleviate Burnout*” and “*A Vision for a Person-Centered Health Information System*.”<sup>1</sup>

The NAM Action Collaborative also established a workgroup that focused specifically on identifying opportunities to better align documentation requirements with the current practice of health care delivery and promote clinician well-being. The work of this group was shared at a meeting on October 4, 2018 that included many different stakeholders, including representatives from physicians, hospitals, commercial payers, CMS, ONC, and electronic health record vendors.

### **General Comments**

Providing safe and effective care is of utmost importance to the AAMC and our members. Many of the AAMC’s member institutions were early adopters of EHR technology; they have helped to pioneer its development and use and are committed to providing quality care using these systems. The AAMC supports the three burden reduction goals that are identified in the draft Strategy. When developing the final Strategy, the AAMC recommends that ONC and CMS consider enhancing focus on the following topics:

1. **Interagency collaboration**—the AAMC supports ongoing efforts by the Administration to address the changing nature of technology use in health care including documentation, interoperability, and data security. We recommend that the final Strategy specifically identify these initiatives and outline the intended approach to achieve interagency collaboration across health IT related initiatives so that efforts are highlighted and can be coordinated and aligned.
2. **Administrative burden related to clinical research**—the draft Strategy references that the 21<sup>st</sup> Century Cures Act amended the Health Information Technology for Economic and Clinical Health (HITECH) Act to add section 13103, which requires HHS to consider “EHR-related burden specific to public health and clinical research.” The draft Strategy identifies how health IT impacts public health reporting, but it does not reference ways

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<sup>1</sup> <https://nam.edu/a-vision-for-a-person-centered-health-information-system/>  
<https://nam.edu/care-centered-clinical-documentation-digital-environment-solutions-alleviate-burnout/>

that HHS intends to reduce unnecessary burden related to clinical research documentation. The report should reference that ONC will work with FDA and NIH to identify specific actions and recommendations to include in the final strategy that address clinical research documentation. AAMC also welcomes the opportunity to engage with ONC on this subject.

3. **Specify timeline and accountable party**—AAMC recommends that HHS report out, on an annual basis, the progress made toward achieving each of the recommendations outlined in the report, so that the stakeholder community is informed of the status. AAMC also recommends that the final Strategy include an additional column in the “Strategies and Recommendations” table (beginning on page 19 of the document). This new column should identify which HHS agency has the lead responsibility for the identified objectives.
4. **Acknowledge other technological advances**—the final Strategy document should acknowledge opportunities to leverage technology to address clinician burden. For example, CMS has taken great strides in this past year toward expanding the use of telehealth by recognizing new telehealth services for coverage. HHS should consider additional steps that the agency could take to expand access to telehealth services and pay appropriately for services that take full advantage of communication technologies.

In addition to these overarching topics, the AAMC makes the following specific comments and recommendations to the draft Strategy.

### **Clinician Documentation**

The AAMC strongly **supports reducing administrative burdens to allow physicians and other health care professionals to devote more time to patient care**. Excessive documentation requirements have made it difficult for physicians and other health care professionals to locate important information in the medical record about the patient’s current condition, recent changes, and the plan of care in the medical record. The medical record has become bloated in order to meet billing rules, which has led to difficulties in following the care and proposed management of patients and has impeded quality care in some cases. Several of the changes to documentation requirements that ONC discusses in this draft strategy report would help to alleviate these problems, lead to improved patient care, and better align with current medical practice and the use of electronic medical records.

The AAMC appreciates CMS’s recognition of the administrative burden physicians and other health care professionals experience and the adoption of a policy in the final physician fee schedule rule that would allow physicians (effective 2021) to choose their method of documenting office visits among the following options: 1) medical decision-making; 2) time, or 3) the current framework of 1995 or 1997 E/M guidelines. We commend CMS for eliminating the requirement that physicians document in accordance with the 1995 or 1997 E/M guidelines. Use of the 1995 or 1997 E/M guidelines for documentation should be voluntary until CMS transitions to the new documentation guidelines.

The 1995 and 1997 E/M guidelines were developed at a time when medical records were maintained on paper and clinicians worked largely independently. With the advent of the EHR, team-based care, and other changes over the past two decades, the E/M Guidelines are outdated and have led to much of the “note bloat” that is seen in EHRs. The current documentation requirements (such as noting negative review of systems) impose an onerous burden on physicians while providing little benefit to patients. In some cases, the requirements impede patient care by making it difficult to locate the physician’s differential diagnosis or plan of care. The physician spends less time with the patient since so much time is spent on ensuring the information to support billing is included in the medical record.

While we strongly support the documentation changes discussed in this draft Strategy, **we continue to have concerns about the potential for negative unintended consequences related to single payment rate for levels 2 through 4 for outpatient/office visits that was finalized in the 2019 physician fee schedule rule.** Specifically, we remain concerned about the potential impact that these payment policies would have on patient access to care. The impact of a single payment rate for levels 2 through 4 would vary based on specialty and patient characteristics, with physicians who see patients with more complex conditions potentially receiving lower reimbursement. Faculty physicians in academic medical centers typically see more complex patients and therefore this payment policy will have an even greater negative impact for them. Although the CMS payment policy pertains to Medicare payments for outpatient and office visits, it is likely that in the future CMS will be expand this payment approach to other settings. Commercial payers also may set their payment rates in line with this model, as ONC suggests in this strategy document. This expansion would further compound the negative impact.

If the single payment rates are implemented, patient access to necessary health care services could be jeopardized. It may provide an incentive for some physicians to avoid treating more complex patients, meaning that many of these patients will go to academic medical centers that will continue to treat them but at a greater financial loss. Yet another unintended consequence is that the significant reductions in payment to providers with complex patients could result in providers giving patients shorter and more frequent visits. Or the payment may not be able to support the resources needed for a comprehensive visit of these complex patients. This potential outcome would cause patient dissatisfaction, may increase costs to patients as there will be a co-pay for each visit, and may jeopardize the best care which may be best achieved through longer visits. At a time when there are growing physician shortages, the shortages may be exacerbated for specialties that face significant cuts in payment.

We believe that there are alternatives to CMS’s payment approach that would more accurately reflect the resources used to provide patient care as Congress intended when it put in place Medicare’s resource-based relative value system. In addition, we believe that CMS can simplify the documentation by allowing physicians to elect to document based on medical decision-making only or time without setting one payment rate for code levels 2-4.

The AAMC is pleased that CMS has indicated that it will continue to obtain ongoing stakeholder input about the payment and documentation requirements that were established in the final physician fee schedule rule. We also commend HHS for indicating in recommendation 3 of the clinician documentation section of the draft Strategy that it plans to “obtain ongoing stakeholder

input about updates to documentation requirements.” The AAMC is committed to working with CMS on future refinement of the coding structure and payment for E/M Services.

The AAMC strongly supports the recommendation on page 46 of the document to leverage the data that is already present in the EHR to reduce the documentation burden. Many pieces of information that clinicians enter into clinical notes already exist in the EHR. In this draft Strategy, ONC references the provision finalized in the 2019 physician fee schedule final rule that physicians would not be required to re-document required elements of history and exam that are already present in the medical record. Instead, the information can be reviewed, updated, and signed off by the billing practitioner. The AAMC strongly supports this change that would enable the physician to focus documentation only on what has changed since the last visit rather than re-documenting. Many EHRs have documented allergies, history of prior medical conditions and surgical conditions, family history, social history, and educational history. The review of systems also may not have changed or may not be germane to the problem at hand and may already be delineated in the medical record. None of these need to be repeated in a note unless there have been changes since the last visit or its pertinent to the differential diagnosis that the physician is evaluating.

There also is an opportunity to recognize the importance of team-based care by broadening acceptance of clinical notes in EHRs from the entire team for the service rendered to the patient. All the documentation does not have to be contained exclusively in a physician-specific note. Notes from nurses, pharmacists, residents, students, and the rest of the care team can contribute to documentation. There is no need for a physician to re-write a note that already exists to meet documentation requirements to comply with rules related to billing. Physicians should be able to reference another team member’s note and therefore report in a shorter, more succinct way.

AAMC agrees with the draft Strategy’s recommendation on page 47 that CMS should, where feasible, **explore opportunities to waive certain documentation requirements in APMs when appropriate**. APMs incentivize providers to deliver high quality care while also reducing cost. Unfortunately, there are additional documentation requirements both on clinical characteristics and quality measures that are essential to APMs but significantly increase the overall burden on clinicians as these requirements do not replace but rather escalate the chronicling needs. For example, in the Oncology Care Model, clinicians are required to tally specific Hierarchical Condition Categories (HCCs) that are otherwise noted in the record but need to be re-recorded. Similarly, clinical and staging data which is in the record must laboriously be extracted and reported in OCM specific data collection tools. The additional funds in OCM that were designed to enhance care are in reality are being used for data entry. When CMS requires additional documentation, there should be a specific fee to pay for the additional work.

The AAMC strongly supports the recommendation on page 48 to “**Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.**” We believe that educating and training of clinicians regarding documentation requirements and best practices is essential to reducing burden while ensuring high quality care. Implementation of any new coding structure, new payment system, or other changes would involve substantial education of physicians, and other staff and sufficient time is needed to

ensure this occurs. Also, vendors need adequate time to make changes to their EHR systems to incorporate any changes from refinements.

We also support ONC's recommendations **to standardize data and processes around ordering services and related prior authorization, to evaluate process and clinical workflow factors contributing burden associated with prior authorization, and to support automation of ordering and prior authorization processes through adoption of standardized templates and data elements.** Physicians strive to deliver quality health care in an efficient manner. However, the frequent phone calls, faxes, and different forms that physicians and their staff must complete to obtain prior authorizations hinder efficient care. Rules and criteria for prior authorization must be transparent and available to the physician at the point of care. In addition, if a service or medication is denied, the physician should be provided a reason for the denial and other alternatives that may be covered (e.g., different medications). Finally, prior authorizations need to be studied in general to determine if they meet the goal of the authorization or decrease use because of the complicated steps required to complete. Care should not be denied because a physician and/or patient can not jump through complicated opaque hoops.

Adopting a standardized form and process for prior authorization among all payers would reduce burden. Also, prior authorization should be waived in certain alternative payment models that have financial incentives in place to provide cost-effective, quality of care and accountability.

### **Health IT Usability and the User Experience**

The AAMC appreciates ONC's acknowledgment that identifying end-user needs and including them in the health IT development process is essential to reducing unnecessary burden. Those who use health IT products are best suited to identify the challenges posed by these products and make suggestions for what changes to these systems would benefit the overall user experience.

AAMC agrees with the strategy to **“improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools” (pg. 51)** and supports ONC's goals of bettering aligning EHR system design with real-world clinical workflow, improving clinical decision support usability, improving clinical documentation functionality, and improving presentation of clinical data within EHRs. However, the draft strategy does not specify the process for making and overseeing configuration and implementation changes, nor does it discuss how ONC can assist in enhancing future development of clinical information systems. The AAMC encourages ONC to include these specifics in the final document.

The AAMC agrees with ONC's strategy (pg. 55) to **“promote harmonization surrounding clinical content contained in health IT to reduce burden.”** It is important that health IT products capture and present data in a standardized manner so that the clinician sees uniform data regardless of the health IT system. Standardizing data across products will both improve usability and increase patient safety. The AAMC supports ONC's approaches for standardizing medication information, order entry content, and results display in health IT. We recommend ONC provide further details about how they intend to identify which common clinical tasks should be standardized, ways that members of the clinical and health IT communities will be

involved in this process, and the process by which ONC intends to implement these recommendations.

Health care institutions provide ongoing training to clinicians using their health IT systems. However, training alone will not resolve the current administrative burden associated with EHR use and clinical documentation. Clinicians are spending increased time with these systems, which interferes with how they interact with their patients. Many health systems continue to invest in health IT implementation and training, yet the usability of these systems remain burdensome to clinicians. AAMC appreciates that ONC acknowledges (page 56) that user training is essential to operating health IT systems but **encourages ONC to not overlook how systems development and configuration can also impact training and contribute to burden. Vendors and developers should be encouraged to identify ways to update health IT products so that training is not overly burdensome, and users can more easily navigate system changes.**

### **EHR Reporting**

The AAMC is pleased that ONC plans to address the EHR-related burden associated with federal programs that require health care providers to report performance data using health IT, particularly the Promoting Interoperability Programs. The current design and administration of these programs is burdensome and meeting the reporting requirements can be difficult.

In 2019, CMS made some significant changes to the program requirements for the Promoting Interoperability category (PI) in MIPS and the Medicare Promoting Interoperability Program for hospitals. These changes included aligning the MIPS and hospital programs and changing the scoring methodology for the programs. The AAMC commends CMS for aligning the programs, which has helped to reduce provider burden and increase the focus on interoperability and for its efforts to reduce the complexity of the scoring methodology. However, we remain concerned about a number of aspects of the Promoting Interoperability program and encourage additional refinements to further improve flexibility and reduce burden. Specifically, the MIPS program retains the rigid, all-or-nothing scoring methodology of the PI category. CMS should consider aligning with the inpatient PI program by only requiring 50 performance category points to fully satisfy the PI category and receive 25 points toward the final MIPS composite score.

CMS should allow clinicians to select from a larger list of clinically focused measures that center on the areas of HIT-related improvements that would be most beneficial to their practice and patients. This will be more effective in meeting the goals of increasing the use of HIT and improving patient care. Moreover, this will create more synergy between the PI Category and the Quality and Improvement Activities Categories, which include a menu of measures or activities to choose from. Allowing clinicians to choose the measures that are meaningful to their practice and lowering the point minimum for this category would significantly reduce burden.

We are encouraged by the statement in this report on page 58 that in future rulemaking CMS will evaluate the use of measure combinations that would give clinicians a recommended set of related eQMs, Promoting Interoperability health IT measures, and improvement activities that are tied by a common thread. **In addition, we support aligning measurement with clinical**

**workflow, so that data collection for each measure does not result in unnecessary extra steps in the use of health IT in patient care.**

We support the recommendation on page 58 that **HHS explore opportunities to reward innovative uses of health IT and advancements in interoperability that improve patient care for patients**, such as bonus scoring for the use of Health IT. In addition, we urge CMS and ONC to take steps to allow physicians in the MIPS program to maximize their scores across the Quality, Promoting Interoperability and Improvement Activities performance categories by participating and reporting on a smaller set of activities that are less burdensome and use health IT in innovative ways. We urge CMS and ONC to solicit input from stakeholders to develop multi-category measurement models.

The AAMC supports efforts (referenced on page 60 of the report) to improve feedback reports to clinicians regarding program performance under the Quality Payment Program. Unfortunately, the feedback reports that were provided in Year 1 of the program did not provide sufficient information to be useful for performance improvement. **In order to be actionable, the feedback reports need to include more beneficiary level data and more provider specific data, and more information on utilization of services outside the practice and they must be timely.** Feedback on their performance from two years ago is not actionable information for providers. In the future, we encourage CMS to shorten the time frame for feedback so that providers can take steps to improve quality.

### **Public Health Reporting**

Prescription drug monitoring programs (PDMPs) serve as a valuable state-level tool in informing providers' prescribing based on a patient's history of controlled substance prescriptions. The AAMC agrees with ONC that there should be **improved interoperability between health IT and PDMPs through common industry standards** (page 65). Improving integration of PDMPs into the clinical workflow would help to reduce administrative burden on clinicians.

The AAMC also supports HHS's strategy to **identify the various reporting requirements across federally-funded programs in order to harmonize these requirements and reduce data collection and reporting burden on clinicians** (page 66).

The AAMC agrees with ONC that **"HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care."** The Association will provide comments to the Office in Civil Right on response to the Request for Information on Modifying HIPAA Rules to Improve Coordinated Care (83 Fed. Reg. 64302, December 14, 2018 which includes opportunities to comment on coordinating HIPAA Privacy Rules with 42 CFR part 2.

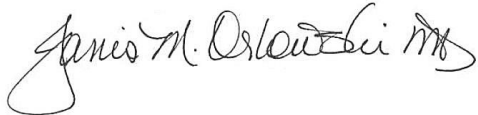
### **Conclusion**

The AAMC appreciates the opportunity to provide comments on ONC's draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*. We



value ONC's commitment to identifying health-IT challenges contributing to clinician burden and are happy to work with ONC as this strategy continues to develop. We look forward to continued engagement as the health care community moves toward achieving interoperability and reducing administrative and regulatory burden. If you have any questions regarding these comments, please feel free to contact Gayle Lee at [galee@aamc.org](mailto:galee@aamc.org).

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski M.D." with a stylized flourish at the end.

Janis M. Orlowski, M.D., M.A.C.P.  
Chief Health Care Officer

cc:

Ivy Baer, AAMC

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