June 16, 2025

Submitted Electronically

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: Request for Information; Health Technology Ecosystem; CMS-0042-NC
7500 Security Boulevard
Baltimore, MD 21244

RE: Physician Clinical Registry Coalition's Comments in Response to the Request for Information on Health Technology Ecosystem (CMS-0042-NC)

Dear Administrator Oz:

The ASTP/ONC collaboration with the American Board of Family Medicine ("ABFM")[1] found that only 8% of family physicians reported that information obtained from organizations that use different EHR developers' products than their own was very easy to use.[2] In contrast, 38% reported that information obtained from organizations that use the same EHR developer's product was very easy to use.[2] At the point of care, family physicians reported that the electronic transfer of medication data from outside organizations, the ability to find it, and the ability to use it to reconcile differences was only possible 13% of the time.[3] This is not safe for patients and creates tremendous burden for clinicians.

What data is valuable, but hard for patients and caregivers, or app developers and other technical vendors, to access for appropriate and valuable use (for example, claims data, clinical data, encounter notes, operative reports, appointment schedules, prices)? All of the above. Our annual, cross-sectional census of 106,000 family physicians has a 100% response rate making it both nationally representative and reliable. As noted above, the only environmental factor improving interoperability is monopolization of the EHR marketplace by a few EHR vendors. Interoperability across different EHR platforms remains not only poor, but dangerous. The danger from poor interoperability will grow as artificial intelligence clinical decision support tools grow because these tools depend on access to health care data from across the sectors where patients receive care.

What specific opportunities and challenges exist to improve accessibility, interoperability and integration of clinical data from different sources to enable more meaningful clinical research and generation of actionable evidence? Interoperability

policy should be strengthened to incentivize accountability for delivering actionable data at the point of care. It should require data be useful in routine decision-making during a patient's visit and should support reliable machine learning.

How important is it for healthcare delivery and interoperability in urban and rural areas that all data in an EHR system be accessible for exchange, regardless of storage format (for example, scanned documents, faxed records, lab results, free text notes, structured data fields)? It is extremely important and it is not regardless of storage format. The transmission of scanned, faxed, pdf records should be only allowed as a backup method to true electronic transfer as none of these support timely or safe care.

Please address all of the following:
a. Current challenges in accessing different data formats. It is common for EHR vendors to deliver thousands of multi-page pdfs when clinics transition from one EHR platform to another. A 400-page patient record in pdf format is not useful in a patient visit and when compounded by thousands of patients is a strong disincentive for practices to change EHRs. It is functionally a data blocking strategy and is widely recognized as being such.

b. Impact on patient care quality. The findings noted above demonstrate that interoperability remains poor for most family physicians. The American Board of Family Medicine also runs the largest CMS-certified primary care Qualified Clinical Data Registry in the country and we know from hundreds of practices that they routinely experience difficulty with data interoperability. Both sources suggest that this likely to be one of the greatest threats to patient care quality and safety. Given that AI/ML rely on reliable access to patient data in supporting clinical decision making and quality assessment, this threat will grow if interoperability remains poor.

c. Technical barriers to full data accessibility. Most of the barriers to full data accessibility are not technical, they are by design. EHR vendors create tremendous friction for changing platforms while checking boxes for interoperability compliance. As a certified QCDR we experience this as difficulty getting access to EHR data even when practices want our help in turning those data into quality measures and population health data for their patients. One vendor continues to refuse while others make it financially difficult for practices. Many Health Information Exchanges say the same. So, even the marketplace mechanisms trying to get around data blocking struggle to improve the liquidity of patient data for care improvement. Foot-dragging on implementation of FHIR or incomplete implementation of FHIR is a recent example.

d. Cost or privacy implications of making all data formats interoperable. Privacy implications are real but are increasingly a smokescreen for interoperability. There are good technical solutions to this that have been well-tested in financial sectors. Cost is not trivial, but it too is a created barrier more than a real one. One cloud-based EHR vendor recently moved from charging exorbitant fees for pushing EHR data to our QCDR to charging per-transaction fees that put participation in the registry out of financial reach for most practices. Cost and privacy issues are increasingly used to inhibit interoperability at a time that technology drives both of those issues down.

The American Board of Family Medicine is collaborating with ASTP/ONC to help shed light on the real problem that interoperability remains despite Congressional and Executive efforts and expense. It is a significant source of burden and burnout for clinicians and a growing threat to patient care quality and safety.[3] The ABFM is similarly sharing data with the California Center for Data Insights and Innovation as it also seeks to improve interoperability. We are committed to helping our federal and state partners understand this problem and the risks it poses. Thank you for this opportunity to comment.

Sincerely,

Robert L. Phillips, Jr MD MSPH
Executive Director, The Center for Professionalism & Value in Health Care
American Board of Family Medicine Foundation
Member, National Academy of Medicine

1. ONC Awards Cooperative Agreement to American Board of Family Medicine | ABFM | American Board of Family Medicine. Accessed October 5, 2023. https://www.theabfm.org/about/communications/news/ONC-Awards-Cooperative-Agreement-to-American-Board-of-Family-Medicine

2. Everson J, Hendrix N, Phillips RL, Adler-Milstein J, Bazemore A, Patel V. Primary Care Physicians' Satisfaction With Interoperable Health Information Technology. *JAMA Network Open*. 2024;7(3):e243793. doi:10.1001/jamanetworkopen.2024.3793

3. Holmgren AJ, Hendrix N, Maisel N, et al. Electronic Health Record Usability, Satisfaction, and Burnout for Family Physicians. *JAMA Network Open*. 2024;7(8):e2426956-e2426956. doi:10.1001/jamanetworkopen.2024.26956