September 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1654-P

Dear Acting Administrator Slavitt:

Health IT Now (HITN) is pleased to submit our comments on the *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model* proposed rule. HITN is a diverse coalition of health care providers, patient advocates, consumers, employers, and payers who support the adoption and use of health IT to improve health care and to lower costs.

Overall, HITN supports the health IT measures in the proposed rule because the technology can help improve patient safety and healthcare outcomes by giving healthcare providers, patients, and their caregivers the tools they need to manage their health and wellness. Wide availability, ease of use, and familiarity with these technologies allow patients and their caregivers to integrate disease management and wellness activities into their daily routines. This technology increases adherence to care plans and reduces preventable hospitalization and associated costs. Health IT enables care providers to access necessary information at the point of care, which can improve the efficiency and quality of care delivery.

Our comments on the policies included in the proposed rule are outlined below.

Telehealth

HITN strongly supports the proposed additions to covered telehealth services. We realize that CMS is restricted by current law. Specifically, HITN supports Medicare reimbursement for physical, occupational, and speech-language therapy services, as well as adding diabetes educators to the list of providers eligible to bill for telehealth services. However, we encourage CMS to go even farther in the final rule and extend telehealth services to the fullest extent allowable and practicable under the law.

We recognize that the Medicare requirements that allow for use of telehealth services in limited fashion are woefully out of date. Because of the narrow view of telehealth held by Congress when it passed the *Balanced Budget Act of 1997*, providers are not allowed the flexibility to design telehealth benefits in a way that works best for them and their patients. The result is that in 2015, Medicare spent $14.4 million on services

delivered via telehealth, or less than 0.01 percent of total spending.[1] Ironically, on a per-service basis, Medicare is required to pay more for services delivered via telehealth than services delivered in-person. HITN believes this is counter to the potential savings that could be realized by delivering services via telehealth because the use of technology in health care can lower costs.

While CMS is constrained in what it can do under the fee-for-service program absent a change in law, HITN urges CMS to utilize flexibility it has been granted in other laws, such as the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), to allow providers to utilize technology as a mechanism of care delivery when the use of such technology can fully substitute for in-person care. MACRA provides that those paid under the Medicare physician fee schedule can elect to be graded on measure performance as a "virtual group." Congressional intent was that technology can act as a care delivery and communication mechanism, substituting for out-of-date requirements that groups of providers must be members of the same organization or practice in order to qualify for practice and group measurement. MACRA is largely built on the concept of allowing for testing and adoption of innovative delivery methods to deliver services. In support of such efforts via the virtual group, Congress granted the Secretary of Health and Human Services the authority to "include such other requirements as the Secretary determines appropriate" to make virtual group reporting viable. HITN believes that the Secretary should go forward with the virtual group reporting option for 2017, and should utilize available authorities to explore how services delivered via technology can be recognized under the Medicare program when such service can fully substitute a service delivered via a face-to-face encounter.

Outside of reimbursement issues, in order for telehealth to be useful for people with chronic conditions, CMS must address physician licensure barriers. Currently, physicians must be licensed in the state where their patient is located. While there have been recent efforts to address this effort, such as the Interstate Medical Licensure Compact, these efforts have fallen short of solving the problems of providers and patients. Many patients with chronic conditions require specialty care, and often specialists are few and far between. It is concerning that our current system requires patients to travel substantial distances when telehealth technologies can provide safe and effective care in patients' homes or at their local clinic.

In order to allow for effective coordinated care, Medicare physicians who see patients across state lines using telehealth should not be required to also obtain additional state licenses to provide care to participating beneficiaries. This would follow the model used by the Department of Defense and the U.S. Department of Veterans Affairs, which, like Medicare, are federal programs providing federally-funded services to federal beneficiaries. Reducing licensure barriers in Medicare would reduce costs for taxpayers and facilitate access and lower costs for beneficiaries. HITN believe that states should adopt mutual recognition agreements that would allow medical providers licensed in one state to practice in another state without having to obtain multiple licenses. We believe that the current physician licensure system unfairly restricts physicians and in doing so, impairs the ability of our health care system to be responsive to the access needs of patients. HITN supports policies that incentivize states to adopt reciprocity agreements with other states.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

In general, HITN supports allowing providers the flexibility to utilize digital tools to improve care they are providing to patients. However, we have concerns with CMS' proposed implementation of the Appropriate Use Criteria (AUC) program.

[1] U.S. Department of Health and Human Services. *E-health and Telemedicine.* Prepared by Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation (ASPE). Available at: https://aspe.hhs.gov/sites/default/files/pdf/206751/TelemedicineE-HealthReport.pdf; Accessed: 8/30/16.

We are concerned with the lack of interoperability between electronic health records (EHRs) and clinical decision support mechanisms (CDSMs). Given that there is still a lack of widespread interoperability between certified EHRs, we do not believe the national standards included in certification should be model standards for interoperability. Furthermore, until the health IT marketplace is rid of disincentives for information sharing, HITN strongly objects to exacerbating the problem with additional requirements. Seemingly, CMS' answer for a potential lack of interoperability is to allow providers to use stand-alone CDSMs; however, we do not believe this is a viable option as it requires providers to go outside of their workflow. We urge CMS to further delay implementation of this program in order to align with the implementation of MACRA requirements. We also believe that it is essential that CMS require CDSMs to attest that they do not block information in order to qualify for the program, as is required of CEHRT under MACRA.

Chronic Care Management (CCM) Services

In the past, HITN has been a strong supporter of the CCM services code as it incentivized providers to utilize technology to better coordinate care for beneficiaries with complex chronic conditions. However, with the proposals CMS makes in this rule, there are no longer the same incentives.

In order to reduce provider burden in providing CCM services, CMS is proposing a number of changes related to electronic access and transmission of the patient care plan. Proposals include:

- Elimination of the requirement that an electronic care plan be available to individuals providing CCM services after hours;
- Changing the CCM service element to continue requiring timely (versus previously required 24/7 basis) electronic sharing of care plan information within and outside the billing practice and to allow transmission of the care plan by fax; and
- Requiring the provider to create and exchange/transmit continuity of care documents timely with other providers and no longer would specify how the provider must transmit or exchange these documents.

HITN believes that CMS' efforts to reduce provider burden would be better spent ending, once and for all, the practice of information blocking in federal programs. Information blocking prevents reliable flows of information from emergency departments, hospitals and providers of post-acute care services to track CCM patients receiving care across those settings. Information blocking also prevents reliable information flows that supports care transitions and modifications to a care treatment plan, and creates unsafe patient environments. As we have stated in previous comment letters, the current lack of interoperability between EHR systems is likely to place undue burden on physicians who participate in CCM. HITN encourages CMS to create demand side pressure on vendors by limiting billing for the CCM to only those providers who use systems that do not limit information exchange.

Accountable Care Organizations (ACOs)

CMS proposes to make a number of changes to data reporting and EHR requirements. HITN has long supported utilizing third parties such as a qualified registry, QCDR, direct EHR product, or EHR data submission vendor. Therefore, we support the CMS proposal to eliminate the registration requirement for groups submitting data using third parties as it will reduce provider reporting burden. Additionally, we

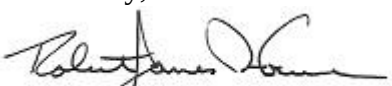
support the proposal to allow EPs who bill under the TIN of an ACO participant have the option of reporting separately as individual EPs or group practices.

We appreciate CMS' focus on improving EHR use in ACOs. While we support CMS' proposals to weight the quality measure regarding EHR adoption twice that of any other measure, to change the specifications of the EHR measure to assess the ACO on the degree of CEHRT use by all providers and suppliers designated as ECs under the MACRA proposed rule that are participating in the ACOs rather than narrowly focusing on the degree of use of CEHRT of only the primary care physicians participating in the ACO, and to consider additional options to further enhance the importance of the measure. Again, HITN encourages CMS to focus on reaching widespread interoperability of EHR products and to once and for all end information blocking. This is even more important as Medicare shifts from fee-for-service to pay-for-value programs such as ACOs. We encourage CMS to work with industry in order to reach this goal and HITN and our members are eager to help.

Conclusion

We appreciate the opportunity to share our comments with you on these important issues and look forward to working with you to ensure the optimization of health IT in the Medicare program.

Sincerely,



Robert James Horne
Executive Director