

Via Electronic Submission to: <http://www.regulations.gov>

September 10, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
7500 Security Boulevard
Baltimore, MD 21224-1850

Re: [CMS-1693-P] Medicare Program; Revisions to Payment Polices under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Share Savings Program Requirements; Quality Payment Program; and Medicaid Interoperability Program

Dear Sir/Madam:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments for the *Revisions to the Medicare Physician Fee Schedule and other Medicare Part B Payment Policies for CY 2019* proposed rule.

Pharmacists are users of health IT and are supportive of interoperability standards, especially those utilizing certified EHR technology (CEHRT). The Collaborative supports the use of particular standards which are important to pharmacists for working with other health care providers, transitions of care, allergy reactions, immunization (historical and administered), immunization registry reporting, medications, medication allergies, patient problems, smoking status, reporting to public health agencies, clinical decision support services/knowledge artifacts, drug formulary checking, and electronic prescribing.

The Collaborative has been involved with the federal agencies, including the Office of the National Coordinator (ONC) and the Centers for Medicaid and Medicare Services (CMS), developing the national health information technology (HIT) framework since 2010.

The following are our comments for proposed areas concerning remote monitoring (e.g., telehealth), promoting interoperability, prescription drug monitoring programs, and the questions regarding new or revised CoPs/CfC/RfPs for the electronic exchange of health information.

II. D. Modernizing Medicare Physician Payment by Recognizing Communication Technology – Based Services (pages 63-94; 585)

The Collaborative supports the use of telehealth for delivering clinical health and person-centered care. Although Medicare routinely pays physicians and other health care providers for several kinds of services provided via interactive communication technology, the proposed payment codes do not include telehealth services provided by pharmacists. Pharmacists are a part of the health care management teams providing Medicare services and are telehealth providers. Telehealth enables pharmacists to connect with established health care management teams, particularly when questions arise concerning medications prescribed or changes to medications, independent of geography. In many instances, especially in rural and underserved areas where telehealth would be invaluable, pharmacists are the first point of contact by patients.

The role of pharmacists in telehealth is expanding. Among the types of telehealth services pharmacists can provide include: medication therapy management, chronic care management (e.g., diabetes), transitions of care, pharmacogenomics, interpretation of diagnostic tests and providing test results, consultations with patients and health care providers, and ambulatory care.

The Bipartisan Budget Act of 2018 modified and removed limitations relating to geography and patient setting for certain telehealth services. Although there may be some statutory restrictions for Medicare telehealth services, we ask CMS to review and consider adding payment codes for those telehealth services that pharmacists provide to Medicare patients and their health care management teams.

III. E. Medicaid Promoting Interoperability Program for Eligible Professionals

Proposed Revisions to the EHR Reporting Period and eCQM Reporting Period in 2021 (pages 466-67)

The Collaborative supports amending the reporting period in 2021 to a minimum of any continuous 90-day period within CY 2021 and to allow states the flexibility to identify an alternative date by which all EHR or eCQM reporting periods must end so that payments may be made before December 31, 2021.

Requiring Use of 2015 Edition CEHRT (page 499)

The Collaborative supports aligning the Medicare and Medicaid Promoting Interoperability Programs and requiring the use of the 2015 Edition certification criteria for CEHRT beginning with the CY 2019 reporting period.

Removing Six Measures from the Promoting Interoperability Program (pages 632-33)

The Collaborative supports the removal of Request/Accept Summary of Care and Clinical Information Reconciliation as two separate measures and combining the actions and functions of those two measures with the new Support Electronic Referral Loops by Sending Health Information and new Support Electronic Referral Loops by Receiving and Incorporating Health Information.

Adding Measures for e-Prescribing (pages 633-43)

The Collaborative supports adding Query of Prescription Drug Monitoring Program (PDMP) as a measure for the e-prescribing objective and National Council for Prescription Drug Programs (NCPDP) SCRIPT 2017071 as the standard for e-prescribing.

Among the challenges regarding PDMP are that nationwide integration of PDMPs is lacking and PDMP usage issues (e.g., real-time interoperable databases among states; real-time response for validating accurate data; standard sets; etc.) that exist vary depending on the state. The Collaborative supports nationwide standardized integration of PDMP, and agrees with CMS that is not without challenges.

Proposed Removal of the Secure Messaging Measure (page 662)

The Collaborative does not support removing the secure messaging measure. Although CMS does not believe the measure aligns with the current emphasis to increase interoperability, the critical reason for retaining this measure is to ensure that MIPS eligible clinicians are using secure systems to communicate with health care providers and patients and to protect patient information in such communications. Interoperability is the ability of different information technology systems and software applications to communicate accurately, effectively, and safely.

Cyber attacks and cyber threats are increasing in the U.S., including attacks on health care organizations. A record number of data breaches occurred in 2017.¹ The Center for Internet Security reports, “The healthcare industry is plagued by a myriad of cybersecurity-related issues.”² One common way that cyber attacks occur is through electronic messaging systems (e.g., phishing).

We strongly encourage CMS to rethink removing this measure.

¹ “2017: Worst Year Ever for Data Loss and Breaches, Info Security. <https://www.infosecurity-magazine.com/news/2017-worst-year-ever-for-data-loss/>

² <https://www.cisecurity.org/cyber-attacks-in-the-healthcare-sector/>

Proposed Exclusions for Immunization Registry Reporting Measure, Syndromic Surveillance Reporting, Electronic Case Reporting, Public Health Registry Reporting, and Clinical Data Registry Reporting (pages 665-66)

The Collaborative supports the proposed exclusions for these measures.

IV. Request for Information

A. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?

Developing a new standard may help, provided such a new standard bans any form information blocking. There are also other aspects that CMS needs to look at that may not necessarily be resolved by a new CoP/CfC/RfP standard. The Collaborative supports exchanges operating openly and transparently. Critical to achieving open and transparent exchanges is ensuring that information blocking is discouraged and does not occur with vendors or health care providers, including removing barriers that may constitute or be perceived as information blocking. The existence of information blocking currently is a concern of the Collaborative and its members. As users of health information technology, pharmacists in all practice settings need unhindered access to the exchange and use of electronic health information.

We recommend that CMS identify and analyze gaps and make available the best solutions to curtail information blocking, including looking further at the Trusted Exchange Framework and Common Agreement (TEFCA). The Collaborative also believes it may be necessary to rethink the HIPAA Privacy Rule. HIPAA is often used as a way to block information sharing.

Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?

The Collaborative believes every effort should be made to ensure a patient's or resident's, et al, right and ability to electronically access their health information without undue burden. Without knowing what existing portals or other electronic means currently in use by many hospitals, the Collaborative cannot provide comment.

Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?

The Collaborative believes that if CMS requires the use of Certified EHR Technology (CEHRT) for interoperability and implements safety protocols, then this should help new or revised CMS CoPs/CfCs/RfPs improve routine electronic transfer of health information.

Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?

The Collaborative recommends that the non-electronic forms of sharing medically necessary information, as noted in the question, continue to be used, particularly if the recipient cannot receive the information electronically. At this stage, interoperability and electronic exchanges of information are not universally in place and being used. This is especially critical for patients, many of whom may not have computers or access to computers.

Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?

As discussed in our first comment, the Collaborative recommends that CMS analyze gaps and identify and make available the best solutions to curtail information blocking, including looking further at TEFCAs. The Collaborative also believes it may be necessary to rethink the HIPAA Privacy Rule under this new paradigm. HIPAA is often used as a way to block information sharing.

What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

The Collaborative continues to support exceptions under the QPP, including CEHRT hardship for small practices.

Communication Between Hospitals and Their Patients and Caregivers

As noted previously, it may be necessary to rethink the HIPAA Privacy Rule. HIPAA is often used as a way to block information sharing. Additionally, the Collaborative also encourages CMS to begin looking at new technologies that are evolving and one day may replace technology that is currently being used. One technology that is now being touted as a possible solution to some interoperability issues in health care is blockchain. Although currently making its way into the financial industry (Bitcoin is one its earliest and larger users), recent reports state that blockchain has strong applicability for health care and health information.

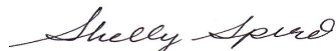
The Pharmacy HIT Collaborative comprises the major national pharmacy associations, representing 250,000 members, including those in pharmacy education and accreditation. The Collaborative's membership is composed of the key national pharmacy associations involved in health information technology (HIT), the National Council of Prescription Drug Programs, and nine associate member encompassing e-prescribing, health information networks, transaction processing networks, pharmacy companies, system vendors, pharmaceutical manufacturers, and other organizations that support pharmacists' services.

As the leading authority in pharmacy health information technology, the Pharmacy HIT Collaborative's vision and mission are to ensure the U.S. health IT infrastructure better enables pharmacists to optimize person-center care. Supporting and advancing the use, usability, and interoperability of health IT by pharmacists for person-centered care, the Collaborative identifies and voices the health IT needs of pharmacists; promotes awareness of functionality and pharmacists' use of health IT; provides resources, guidance, and support for the adoption and implementation of standards driven health IT; and guides health IT standards development to address pharmacists' needs. For additional information, visit www.pharmacyhit.org.

On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on the *Revisions to the Medicare Physician Fee Schedule and other Medicare Part B Payment Policies for CY 2019* proposed rule.

For more information, contact Shelly Spiro, executive director, Pharmacy HIT Collaborative, at shelly@pharmacyhit.org.

Respectfully submitted,



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