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

June 25, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1694-P
7500 Security Boulevard
Baltimore, MD 21224-1850

Re: [CMS-1694-P] Medicare Program; Hospital Inpatient Proposed Payment Systems, et al.

Dear Sir/Madam:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments for the *Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Program (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals* portion of the *Hospital Inpatient Prospective Payment Systems* proposal.

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.

Although the Collaborative supports goals for enhancing health IT to improve patient outcomes, particularly with regard to interoperability, we have concerns with some of the proposed changes. The following are our comments.

Pharmacy Health Information Technology Collaborative
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Removal of Patient Safety Measures (page 1170)

The Collaborative recommends that CMS not remove the Patient Safety and Adverse Events Composite (PSI 90) until the transition from AHRQ to CMS of the recalibrated version of PSI 90 is completed. The proposed rule does not indicate when this transition will be completed.

Propose Removal of Electronic Clinical Quality Measures (eCQMs) (page 1203)

The Collaborative does not support removing the Home Management Plan of Care Document given to Patient/Caregiver from this measure. Plan of care documents are critical for the continuity of care and outcomes once a patient is discharged from the hospital. We ask CMS to further explain how removing the plan of care document reduces costs associated with the payment policy of meaningful measures without affecting patient outcomes.

Clarification of the Measure Logic Used in eCQM Development – Transition to Clinical Quality Language (CQL) (page 1256-57)

In moving forward, the Collaborative supports the use of the Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR), including its recent version (v3.0.1), as part of CQL. We recommend that the recent version also be included in the footnote.

Changes to the Certification Requirements for eCQM Reporting Beginning with CY 2019 (page 1260)

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

Renaming the Program (page 1332)

The Collaborative supports the renaming of the Medicare and Medicaid EHR Incentive Programs to Promoting Interoperability Programs. The name change better reflects the goals of the programs to focus on interoperability and improving patient access to health.

Proposed Performance-Based Scoring Methodology (page 1347)

The Collaborative supports including e-prescribing, health information exchange, provider-to-patient exchange, and public health and clinical data exchange into the smaller set of proposed objectives, which align with the core goals for interoperability for the 2015 Edition.

Proposing to Remove Six Measures (page 1366)

Although the Collaborative could support replacing the Request/Accept Summary of Care and Clinical Information Reconciliation by the new Support Electronic Referral Loops by Receiving and Incorporating Health Information measure, since it includes the functionalities and goals of the two Stage 3 measures it is replacing, this appears to be inconsistent with what CMS proposes on pages 1393-96, where CMS states it is removing these measures for other reasons and is not replacing them (see comments below). We ask CMS for a clarification.

Measure Proposals for the e-Prescribing Objective (page 1370)

The Collaborative supports the requirement to use CEHRT as the sole means of creating a prescription and for transmission of a prescription to the pharmacy under the existing e-prescribing measure.

Query of Prescription Drug Monitoring Program (PDMP) (page 1374)

The Collaborative supports the new proposed measure requiring the query of PDMP for Schedule II opioids; however, we recommend that the proposed measure be refined. As written, the measure only requires that one query be made. It doesn't indicate what the one query is to include: One prescription? Multiple prescriptions? One patient? Multiple patients? It isn't until later in the proposed PDMP section that CMS mentions that it is proposing that multiple Schedule II opioid prescriptions prescribed on the same day by the same eligible hospital would require one query be performed under this measure; not multiple queries. The specific requirements for this should be written directly into the measure so that it is clear.

We also recommend an additional refinement regarding the exclusion criteria mentioned on page 1386, as it is somewhat confusing. CMS states, "the exclusion criteria would be limited to prescriptions of controlled substances as the measure action is specific to electronic prescriptions of Schedule II opioids." If the exclusion is solely for Schedule II opioid prescriptions, then the proposal should state that. By initially saying it is limited to controlled substances implies that it could also apply to other controlled substances prescriptions not just Schedule II opioids.

As for CMS' request for additional thoughts about PDMP, among the challenges regarding PDMP are that a national, centralized PDMP does not exist and PDMP usage issues (e.g., real-time interoperable databases among states; real-time response for validating accurate data; standard sets; etc.) that exist and vary depending on the state. One state, Missouri, lacks a statewide PDMP.

The Collaborative supports the NCPDP SCRIPT 2017071 standard for e-prescribing that can help support PDMP and EHR integration. Additionally, NCPDP developed a detailed plan to standardized PDMPs nationally that would address many of the usage issues.

Proposed Removal of the Request/Accept Summary of Care Measure (page 1393)

The Collaborative does not agree with removing the Request/Accept Summary of Care measure. If, as CMS notes, "that the definition of 'incorporate' within the measure is insufficient to ensure an interoperable result," the solution would be to rewrite the definition and define "incorporate" so that it ensures an interoperable result and aligns with an eligible hospital's or CAH's workflow, process of clinical information reconciliation, patient population, and the referring provider of care rather than removing the measure. Removing this measure also appears to be inconsistent what CMS proposes on page 1366 (see above comment). We ask for clarification regarding this and what is also proposed on pages 1414-16 (see comments below).

Proposed Removal of the Clinical Information Reconciliation Measure (page 1395-96)

The Collaborative does not agree with removing the Clinical Information Reconciliation measure. We also do not agree with the analysis that Clinical Information Reconciliation is redundant to the requirements to incorporate electronic summaries of care in the Request/Accept Summary of Care measure. Clinical Information Reconciliation and Summary of Care perform different functions and are not synonymous or redundant. Clinical information reconciliation enables a user to electronically reconcile data that represent a patient's active medication, problem, and medication allergy list and to create a single reconciled list,[1] which is not the same as a Summary of Care that is used by an EP, eligible hospital, or CAH that transitions or refers a patient to another setting of care. Removing this measure also appears to be inconsistent with what CMS proposes on page 1366 (see above comment). We ask for clarification regarding this and what is proposed on page 1366.

Request for Comment – Potential New Measures for HIE Objective: Health Information Exchange Across the Care Continuum (pages 1414-16)

Although the Collaborative would support this potential new measure, as noted in our comments above, there appears to be inconsistency and confusion with CMS' proposed removal of the Summary of Care measure and then re-including it as part of these potential two new HIE measures.

CMS outlines its rationale for removing the Summary of Care measure (page 1393), citing various problems with workflow, the definition of "incorporate," etc.

[1] https://www.healthit.gov/sites/default/files/standards-certification/2014-edition-draft-test-procedures/170-314-b-4-cir-2014-test-procedures-draft-v1.0.pdf

Under this new section, CMS proposes including Summary of Care for the two new Support Electronic Referral Loops Sending/Receiving measures, while not appearing to address the concerns and problems discussed in its initial analysis for removing this measure. We ask CMS to clarify.

Promoting Interoperability Program Future Direction (page 1418)

The Collaborative supports the Trusted Exchange Framework and Common Agreement (TEFCA) and its six core principles, which should be considered a health IT activity within the HIE objective; though, this should not be in lieu of reporting on measures for this objective. TEFCA would help facilitate interoperability.

Response to Question: 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? (page 1478)

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 analyze gaps and identify and make available the best solutions to curtail information blocking, including looking further at TEFCA. 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.

Proposing to Update EHR Certification Requirements (page 1506)

The Collaborative supports updating the EHR certification requirements by requiring use of EHR technology certified to the 2015 Edition beginning with the CY 2019 reporting period.

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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-centered 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.

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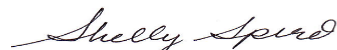
On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on the *Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Program (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals* portion of the *Hospital Inpatient Prospective Payment Systems* proposal.

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

Respectfully submitted,



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