June 3, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

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

Re: CMS-9115-P

Dear Administrator Verma and Dr. Rucker:

AMDA – The Society for Post-Acute and Long-Term Care Medicine appreciates the opportunity to provide our comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule on Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organizations and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-Facilitated Exchanges and Health Care Providers (Proposed Rule)¹ and the Office of the National Coordinator for Health Information Technology (ONC) on the Interoperability, Information Blocking, and the ONC Health Information Technology (Health IT) Certification Program proposed rule. Given the intertwined nature of the topics addressed in the rules, we have elected to submit a combined comment letter for consideration by the Administration.

The Society is the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PALTC) settings. The Society’s 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, continuing care retirement communities (CCRC), home care, hospice, PACE programs, and other settings. In serving this population, these clinicians care for the most high-risk

¹ Throughout the comments, unless otherwise noted, we use the term “Payer” to refer to all of the payers implicated by the proposed rule—the Medicare Fee-for-Service (FFS) Program, the Children’s Health Insurance (CHIP) FFS program, Medicare Advantage (MA) Organizations, Medicaid Managed Care plans (managed care organizations (MCOs), prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs)), CHIP Managed Care entities (MCOs, PIHPs, and PAHPs), and issuers of qualified health plans (QHPs) in Federally-facilitated Exchanges (FFE). We use the terms “beneficiary” and “patient” interchangeably.
and costly group of beneficiaries covered by Medicare and Medicaid programs.

We support the overall intent and direction of the Proposed Rule. Achieving such a daunting imperative as interoperability warrants careful deliberation on the sequencing that’s needed to ensure that foundational items are in place first; the need for adequate, achievable timelines for implementing changes proposed by CMS and ONC; consideration of potential unintended consequences such as minimizing the risks to patient safety and increased provider burden; a means to achieve greater parity across sectors; and policy strategies to advance the business case for interoperability for those that have not received federal incentives to adopt and use health IT.

**General Comments About PALTC Clinicians**

Clinicians that practicing in PALTC setting are unique and important use case for the need for interoperability. These clinicians see patients in multiple locations and must review data from about every part of the healthcare continuum. In order to manage their population effectively they must establish data exchange with multiple electronic health records (EHRs) and gather data from multiple locations in order to successfully report it to CMS under the Quality Payment Program (QPP).

Very often there is misunderstanding of the workflow for these clinicians. In many discussions on interoperability, they are currently invisible and are often viewed as outpatient ambulatory clinicians. There is a notion that an ambulatory based primary care physician follows the patient through the continuum. In reality, this is a misrepresentation. In practice, there are clinicians that specialize in the care of nursing facility (post-acute and long-term care) population. A recent article in *Caring for the Ages* titled “PALTC, The Specialty That Dare Not Speak Its Name”, Dr. Karl Steinberg discusses the growing trend of clinicians that specialize in skilled nursing (post-acute) and nursing home (long-term) patient population. These clinicians interact with the hospitalist, the primary care physician, the long-term care pharmacy (or pharmacies), the facilities they practice in and perhaps most importantly the patients and their caregivers and family members. As many of the patients they see have cognitive impairment, the communication with caregivers and family members is perhaps more important than in any other setting of care. There is a notion that an ambulatory based primary care physician follows the patient through the continuum (See Illustration below).
These clinicians also face penalties in the Quality Payment Program (QPP) for failing to meet the Promoting Interoperability portion of the Merit-Based Incentive System (MIPS). While hospitalists and ambulatory surgical center-based clinicians receive an automatic exemption from the PI category, nursing home-based clinicians must fill out burdensome paperwork on an annual basis to receive an exemption because they have no control over facility EHR choices. The Society has received letters from small practices that have filled out these applications only to be penalized and having to resolve any issues with CMS. This is not consistent with the Administration’s goal to reduce unnecessary paperwork burden. Hence for the last several years, we have requested consideration of an automatic hardship exemption from PI for PALTC clinicians (those who make most of their visits in the SNF or NF place of service). For those who opt in to ACI reporting, there should be an ability to exempt e-prescribing from the reporting requirement for those clinicians who do not have that service available with the nursing home dispensing pharmacies.

Thus, we strongly urge CMS to enact the following policies:

- Provide clinicians practicing in PALTC (nursing facilities) to self-identify themselves as an area of practice (similar to the recent identifier code for hospitalists). The Society submitted a request to the CMS office of Practitioner Services in 2017 and has received no further correspondence from CMS.
- Provide an automatic hardship exemption from PI for PALTC clinicians (those who make most of their visits in the SNF or NF place of service). For those who opt in to ACI reporting, there should be an ability to exempt e-prescribing from the reporting requirement for those clinicians who do not have that service available with the nursing home dispensing pharmacies.
- Provide clinicians practicing in PALTC (nursing facilities) to self-identify themselves as an area of practice (similar to the recent identifier code for hospitalists). The Society submitted a request to the CMS office of Practitioner Services in 2017 and has received no further correspondence from CMS (see Addendum 1).

**Patient Access**

The Society supports the proposed requirement that payers provide patients and as appropriate their caregivers and families with access to their health care data through an application programming interface (API). We agree with CMS that patients should have the ability to decide how their information will be used by consumer-facing apps, and we include ways CMS can incentivize app developers to keep patient health information private.

- CMS should also require payers to provide prior authorization requirements to patients and physicians.
- While physicians must provide information to patients free-of-charge, CMS has not indicated that the same requirement applies to payers. It is unclear who will absorb the associated costs. PALTC clinicians gather data from multiple locations, thus the cost of providing this information could be great.
- CMS should ensure that beneficiaries and the individuals assisting them should have assurances that information provided across settings (e.g., online web portals, smartphone apps, payer policy booklets, etc.) contains consistent information.
- We believe that there are more effective ways for CMS to encourage meaningful exchange of patient health data. We propose that CMS issue guidance to hospitals directing operators to address any legal or policy rationale that prohibits hospitals from releasing clinical records to the receiving provider in advance of a patient’s transfer. We recognize that current regulations...
allow up to 30 days for the hospital to review and send a patients record, but receiving clinical data after the patient is transferred is of little value to clinicians or to patient care. Instead, we recommend that CMS direct hospitals to share clinical records with the receiving provider before the patient is transferred with the expectation that the receiving provider is responsible for verifying that clinical information.

**Incentivize Adoption of HIT in PALTC**

We believe that providing some measure of incentives for PALTC organizations to adopt health IT would go a long way to drive greater interoperability. For incentives to drive rapid change in the rates of health IT adoption and use in PALTC, the benefit must accrue to the purchaser of the EHR or other IT system. We would encourage CMS to consider using the HHS Secretary’s authority under the IMPACT Act to add new quality measures that could incentivize health IT adoption. Specifically, the IMPACT Act requires post-acute care (PAC) providers – Long Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs) and Home Health Agencies (HHAs) – to transfer an individual’s health information and care preferences when transitioning to another setting, including a different PAC provider, a hospital or home by October 1, 2020. We recommend that the Secretary consider crediting those providers that satisfy this quality measure through electronic sharing of information, which could serve as the basis for a business case and thus incentivize PAC providers to adopt and use health IT to meet that quality measure.

Under the IMPACT Act CMS has invested heavily in aligning the clinical vocabularies across PALTC settings, linking questions and responses in the federally mandated assessment instruments to standardized codes (LOINC, SNOMED). The Data Element Library (DEL) is the repository for this vocabulary. Semantic interoperability at the data element level is a foundation of interoperability.

We believe CMS should require acute care facilities to adopt the same vocabulary used in PALTC setting as maintained in the DEL so that there would likely be several positive results including improved efficiency of reuse of clinical information, a contribution to a compelling business case for HIT adoption in PALTC, and the possibility of creating cross setting quality measures that reflect important clinical processes and outcomes all built on a shared clinical vocabulary.

**Revisions to the Conditions of Participation for Hospitals and Critical Access Hospitals**

We appreciate CMS’ proposal to improve care coordination through notifications of admission, discharge, and treatment. We support the intent of the proposal but do have questions about details of the execution. We request that CMS clarify certain aspects of the proposal and address areas where we have identified potential for increased provider burden, including the following:

- How does CMS define an “established care relationship”? How close the relationship must be (i.e., is it a physician who sees a patient once a year? Once a month?)?
- What are CMS’ expectations of physicians who receive ADT notifications? Must physicians review and incorporate into their EHRs every notification? PALTC physicians receive multiple notifications a day on multiple patients from multiple locations. CMS must clear guidance on how these notifications should be handled.
- Will physicians receive payment to review all of the notifications to ensure they do not miss important health information?
- Will physicians be responsible for paying for additional server space to store the additional electronic health information they will receive?
• Will this proposal potentially disproportionately burden physicians who care for high-risk patients?
• How will CMS ensure that hospitals that respect a patient’s request to not share their ADT information—even if there is no applicable privacy law—are not excluded from the Medicare program?
• If a hospital in an area with a limited number of hospitals or specialists is excluded, where will patients in that area go?
• Does threatening hospitals with exclusion from Medicare increase the risk of improper disclosure, particularly given the unclear meaning of “established care relationship”?

We agree with CMS that coordination of care across institutional and non-institutional settings of care, as well as timely, electronic exchange of health information to support patient admission, discharge, and transfer (ADT) is a desirable goal. However, CMS should not attempt to reach this goal by requiring new clinical standards in the form of conditions of participation (CoPs) or requirements. Furthermore, many of the entities at issue are at vastly different stages of health IT implementation and integration; we are unsure that hospitals possess the infrastructure, technology and interoperability capability required for CMS to make ADT notifications a requirement. Rather than trying to spur interoperability and care coordination through additional requirements in the CoPs or elsewhere, CMS should work to provide positive financial incentives for entities to adopt technology and engage in event notifications.

We are concerned that compliance fears and costs associated with new standards could hinder investments and actions to enhance interoperable data exchange. Furthermore, health care stakeholders have not had sufficient time to evaluate the impact of forthcoming regulations and enforcement around information blocking, and the operations of TEFCA and U.S. Core Data for Interoperability (USCDI)—each of which will affect interoperability going forward. We reiterate that acute care should adopt

We strongly suggest CMS explore alternative approaches that can be targeted and piloted before they are scaled.

We believe that there are more effective ways for CMS to encourage meaningful exchange of patient health data. We propose that CMS issue guidance to hospitals directing operators to address any legal or policy rationale that prohibits hospitals from releasing clinical records to the receiving provider in advance of a patient’s transfer. We recognize that current regulations allow up to 30 days for the hospital to review and send a patients record, but receiving clinical data after the patient is transferred is of little value to clinicians or to patient care. Instead, we recommend that CMS direct hospitals to share clinical records with the receiving provider before the patient is transferred with the expectation that the receiving provider is responsible for verifying that clinical information.

Request for Information on Post-Acute Care

The Society joins comments submitted by the LTPAC HIT Collaborative that outline specific policy changes CMS must undertake in order to incentivize adoption of HIT in the PALTC (used interchangeably with LTPAC) sector.

We reiterate that for too long this sector has been left out of the incentive programs that allowed the hospitalist and ambulatory physicians to adopt HIT. Thus, penalty management is not the best approach for improving care coordination. Rather, use of a carrot, not a stick, and incentivizing health information exchange rather than penalizing providers for non-compliance with a requirement when so much of interoperability is beyond the provider’s immediate control.

CMS’ Promoting Interoperability Program serves as an important policy priority, which has created a strong business case for acute and ambulatory providers to adopt health IT. No such business case exists
in the PALTC sector. So, CMS cannot adopt the same expectation that PALTC will adopt health IT at the same rate as those essentially paid to do so.

On the flip side of clinical needs, patients, their families and caregivers also require a complete picture of their care. Due to transitional nature of the PALTC populations that transitions from setting to setting it is not unusual for them to have records with multiple facilities as well as specialists. Having to collect this information from various settings and not having the most complete record results in poor medication management and other harmful events for this vulnerable population. The poor outcomes including rehospitalizations and death have been well reported due to medication errors. Thus, it is critical that this population in particular has access to the complete record with the latest information readily available.

We suggest that CMS:

1) Allow PALTC clinicians and facilities to meaningfully participate and gain share in innovative payment models.
2) Mandate and incentivize acute care to invest in post-acute care as they adopt HIT by adopting the IMPACT Act health data exchange quality measure in the acute care sector.
3) Remove penalties from clinicians practicing in PALTC that were never designed for their type of practice and instead provide bonus points within MIPS.
4) Involve patients and caregivers and the design of patient portals and sharing of information.
5) Allow ample time for adoption and implementation within PALTC. What may be considered a reasonable implementation timeframe for incentivized settings such as hospitals and physician offices, most assuredly would not be considered reasonable for LTPAC and other care settings since these settings have not received federal incentives to adopt health IT, and lag behind in terms of adoption, and especially lag in terms of use of interoperability and engagement in health information exchange. Before arbitrary deadlines for achieving interoperability can be set, foundational components must be put in place. Timelines should be adjusted in relation to milestones.

Thank you for the opportunity to comment on this important rule. If you have any questions please contact our Director of Public Policy & Advocacy, Alex Bardakh at abardakh@paltc.org or 410-992-3132.

Sincerely,

Arif Nazir, MD, FACP, CMD, AGSF
President
Addendum 1

August 9, 2017

Ryan Howe, Director, Division of Practitioner Services
Center for Medicare Management
Center for Medicare & Medicaid Services
Mail Stop C4-01-26
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Howe,

AMDA: The Society for Post-Acute and Long-Term Care Services (AMDA) is the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants and other practitioners working in post-acute and long-term care (PA/LTC) settings. AMDA’s 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other similar settings.

AMDA requests CMS consideration of a new specialty code for long-term and post-acute care medicine. Below we have responded to the criteria that need to be met for consideration.

- Requested specialty has the authority to bill Medicare independently.
  - AMDA members have the capacity and authority to bill Medicare independently on behalf of their patients. In fact, AMDA members are unique in that the majority of their patients are Medicare beneficiaries.

- Stated reason/purpose for code.
  - The current physician specialty codes listed at the Internet Only Manual (IOM), Pub. 100-04, Chapter 26, Section 10.8/2 do not capture the field of long-term care and post-acute medicine. As MACRA is implemented, it is critical to understand the specifics of the practice of long term care medicine.
• Evidence that the practice pattern of the specialty is markedly different from the dominant parent specialty.
  o The current physician specialty codes listed at the Internet Only Manual (IOM), Pub. 100-04, Chapter 26, Section 10.8/2 do not capture the field of long-term care and post-acute medicine. Currently, AMDA members bill under the codes for Family Practice (08), Internal Medicine (11), Osteopathic Medicine (12) or Geriatric Medicine (38). However, these codes do not fully encompass the field because they are either too complex or they have other extraneous components lacking in the other fields such as visits are often conducted at multiple skilled nursing facilities.
  o There are three differentiating factors for AMDA members.
    ➢ AMDA members take care of frail elderly with multiple chronic conditions whereas the general practice of internal or family medicine predominately take care of the healthier elderly. The clinical competence to take care of this population differs from the current competence obtained in general internal or family medicine.
    ➢ The second factor is the setting itself. Physicians need to have special knowledge and skills to comply with the vast regulatory framework of the nursing facility (SNF/NF) patients and residents.
    ➢ The third factor is the cost of taking care of this population. The current value-based reporting programs highlight the need to separate physicians taking care of this population from internal/family medicine physicians. Quality resource and use reports show that AMDA members take care of a much higher cost population and are penalized because they are unable to differentiate themselves from the larger specialty.

• Evidence of any specialized training and/or certification required.
  o Medical directors in post-acute and long-term care settings including: skilled nursing facilities, nursing homes, continuing care retirement communities, veteran’s affairs, subacute care, home care, and hospice are eligible for certification. Once awarded, certification is valid for six years, after which recertification is required to maintain ABPLM CMD status.
  o The American Board of Post-Acute and Long-Term Care Medicine (formerly the AMDA Certified Medical Director Program) was developed by AMDA in 1991, after three years of research and development using surveys, consensus conferences, and experts to define the core skills and knowledge necessary for effective medical direction. The ABPLM currently offers a certification program for medical directors in post-acute and long-term care medicine (ABPLM CMD) and is exploring development of a credential for attending physicians in post-acute and long-term care settings. The ABPLM CMD program is administered by the American Board of Post-Acute and Long-Term Care Medicine (AMDCP), an independent not-for-profit organization.
A 2009 study, commissioned by the AMDA CMD program found that having a CMD contributes positively to a nursing home’s quality of care. Analysis of data showed that quality scores represented a 15% improvement in quality for facilities with CMDs. The study appears in the July 2009 issue of the Journal of the American Medical Directors Association (JAMDA).

Since the program's inception, over 3,500 physician medical directors have received the CMD designation.

- Requested specialty treats a significant volume of Medicare patients.

- The CMS Nursing Home compendium 2015 edition includes the following information about all billed providers based on all the skilled nursing facility codes 99304-10, 99315-16, 99318:
  - All Billed providers for 2014: 44,978
  - Number of nursing homes for the fourth quarter of 2014: 15,634
  - Residents in nursing home for calendar year 2014: 1,400,000

- Is the specialty recognized by another organization such as the ABMS?
  - The specialty is not recognized by another organization such as the American Board of Medical Specialties (ABMS) or the American Board of Physician Specialties (ABPS).

- Does the Specialty have a corresponding Healthcare Provider Taxonomy Code?
  - There are at least two relevant crosswalks on the CMS Supplier to Healthcare Provider Taxonomy dated November 12, 2015: A1(8) Skilled Nursing Facility, 31400000X – Nursing and Custodial Care Facilities/Skilled Nursing Facility, A3(10) Other Nursing Facility, 313M0000X – Nursing and Custodial Care Facilities/Nursing Facilities.

We look forward to working with you to secure a new specialty code for long-term and post-acute care physicians. If you have questions on this letter or require a meeting, please contact Alex Bardakh at abardakh@paltc.org or (410) 992-3132.

Sincerely,

Heidi K. White, MD, MHS, M.Ed., CMD, President