June 26, 2018

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

Sent Via Electronic Submission

RE: Request for Information on Promoting Interoperability & Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health & Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers, which was included in Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, May 8, 2018.

Dear Administrator Verma:

The Long Term and Post-Acute Care Health Information Technology Collaborative (LTPAC Health IT Collaborative) appreciates the opportunity to share our comments in response to the Request for Information on Interoperability included in the prospective payment system proposed rules for Inpatient Hospitals, Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNFs) for Fiscal Year 2019. The Collaborative is a public-private group of stakeholder organizations representing associations, providers, policy-makers, researchers, vendors, and professionals with a mission to coordinate the sector and maintain alignment with the national priorities. The Collaborative was formed in 2005 to advance health information technology (health IT) issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders. Collaborative members include national associations representing clinicians, providers, information technology developers and researchers with expertise in the long term and post-acute care (LTPAC).
We recognize that adoption of health IT by LTPAC, behavioral health and other providers excluded from incentive funding for Meaningful Use under the Health Information Technology for Economic & Clinical Health (HITECH) Act has lagged behind incentivized hospitals and providers. We do not believe it is appropriate to further disadvantage these providers by adding requirements for interoperability as a Condition of Participation in Medicare and Medicaid.

**Coordinating Efforts with Other Federal Health IT Policy & Initiatives**

The LTPAC Health IT Collaborative supports CMS’ efforts to increase the adoption and use of health IT to improve care coordination; however, it is not clear how CMS’ efforts fit with federal health IT policy and other HHS initiatives.

- We have watched the development of CMS’ Data Element Library (DEL) and applaud CMS for making it publicly available as of June 21, 2018. We are pleased to have the DEL as a publicly available, centralized, authoritative resource for standardized data elements and related mappings to health IT standards, which will be referenced on CMS.gov and in the ONC Interoperability Standards Advisory (ISA). Importantly, we believe the DEL brings us a step closer to semantic interoperability. It also serves as a reminder of the painstaking, laborious process involved in setting national standards that can support health information exchange across all settings. The RFI does not explain how these federal initiatives will meld together to deliver on the promise of health IT for improving care coordination and achieving much needed efficiencies without added burden, which CMS is trying to eliminate under its Meaningful Measures initiative.

- We recommend the following:
  - CMS more clearly articulate how the DEL relates to the Trusted Exchange Framework and Common Agreement (TEFCA) and US Core Data for Interoperability (USCDI).
  - CMS provide examples or concepts for how the assessment data elements can be reused for improving care coordination across the continuum and achieving much needed efficiencies.

The Request for Information on Interoperability clearly states that HHS considers encouraging adoption and use of health IT along with exchange of health information a priority. It is less clear how HHS will fulfill the intent behind the 21st Century Cures Act (now Public Law 114-255) in furthering electronic sharing of health information, by further defining information blocking (i.e., practices that are likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information) and ultimately, ensuring interoperability.
• We ask for clarification as to how HHS, CMS and ONC plan on putting together the pieces of the interoperability puzzle, including the DEL, TEFCA and Cures Act provisions.

As CMS considers changes to promote health IT adoption and use, and encourage exchange of health information across care settings, we ask that the Agency consider the divergent federal requirements that impact vendors’ ability to innovate and capacity for advancing health IT. LTPAC providers and vendors alike are working to integrate multiple changes that range from implementing a new Medicare Part D e-prescribing standard (*i.e.*, NCPDP Script 2017071 takes effect January 1, 2020) to planning for the overhaul of the SNF payment system that will shift from RUG-IV to the proposed Patient Driven Payment Model (PDPM). In addition, CMS’ revamping of its Quality Improvement Evaluation System (QIES) and Automated Survey Processing Environment (ASPEN), which will build an entirely new platform for quality and other reporting, is expected to launch by 2020. These are not minor endeavors, but initiatives that will take time, planning and resources to implement.

• The Collaborative encourages CMS and ONC to work with us on how best to manage these changes and plan for incremental use of health IT/interoperability standards.

**Recommendations for Advancing Interoperability**

The Collaborative, which was established in 2005, has been meeting weekly or biweekly ever since. We understand the value of bringing diverse stakeholders together to address complex policy issues that affect our various members and the LTPAC sector as a whole. We are heartened to see that CMS and ONC have taken a similar approach by sharing staff across agencies who have expertise in quality measurement, clinical operations and health information technology. We see this team approach as highly beneficial to CMS and ONC, and to the policies being advanced by HHS. We encourage CMS to consider other ways that would bring alignment to the data, standards and quality measurement across the historical silos that exist at CMS.

We recognize that changing CoPs/CfC/RfPs is a most powerful tool for CMS to affect provider behavior. While we agree changes are needed, we believe it is premature to pull this policy lever as the infrastructure is not fully in place and there are many more steps to take to incentivize timely exchange of health information before considering changes to CoPs. Therefore, at this time we do not believe that changing the Medicare & Medicaid Conditions of Participation (CoPs) is the best way to encourage more timely exchange of information.
• Instead, we recommend that CMS focus on clearly defining “medically necessary information” to be exchanged as well as ensuring that information can be exchanged in an interoperable manner.
• Additionally, CMS could explore different mechanisms for incentivizing exchange such as extra credit for use of interoperable health IT when reporting a quality measure.
• CMS should consider how the new Promoting Interoperability Program might incentivize eligible hospitals – perhaps through a new quality measure – to make care coordination and care transitions to LTPAC settings a priority.

We share our concern that conditions do not exist currently to support health IT adoption by those who have not received HITECH Act funds (e.g., LTPAC and Behavioral Health providers). These providers are missing more than a compelling business case – there is limited access to low cost health IT and no commonly shared vocabulary for use across the multiple domains of health care and support services. We anticipate that API-based information sharing will continue to evolve and will likely solve the technological and cost barriers to electronic information sharing for those left out of Meaningful Use incentives.

A semantically standardized vocabulary is complex to build, but not impossible given the extensive work that has been done to date. This is the critical gap. Without widely adopted semantic standards, interoperability is impossible – even with a business case and low cost health IT. Changing the CoP/CfC/RfP standards will not directly address this gap.

We propose the following, high-level approach to work toward building a semantically standardized vocabulary. We note that each of these proposed steps will require a significant investment.

1. Continue to focus on all types of care transitions of care (broadly defined to include transfers of responsibility between providers, teams and settings) moving from high volume/high impact to low volume/low impact.
   a. Specify the site-specific, essential data elements for each transition by asking each care site what information is needed from the sending site recognizing that the data set will depend on the type of transition, the sites involved and the individual’s conditions.
   b. Harmonize the data elements required by each care site and create a master data set.
   c. Establish semantic standards for each data element.
   d. Modify, where necessary, the CMS Transition of Care Summary content requirements for each transfer type using the harmonized data set to match the data needs of the receiving care site.
e. Modify quality reporting requirements for all provider types and settings (including physicians and hospitals) to include metrics regarding the collection and communication of information required at transitions, as well as timeliness and completeness metrics, ensuring that we are not adding to providers’ burden in complying.

f. Base future quality and regulatory reporting on elements in the standardized data set to maintain alignment between clinical needs, reporting requirements and semantic standardization.

2. Collaborate with other parties to establish other standardized processes and data sets required for interoperability:
   a. Individual authentication (e.g., “how do we know it’s you,” and “how do we know it’s the right you”)
   b. Individual authorization for data use (starting with the TEFCA requirements)

3. Establish, test and demonstrate incentives and payment models that encourage providers that were not eligible for HITECH funding, who may lack or lag behind in the adoption of health IT, to implement health IT solutions and effectively participate in the exchange of standardized information defined in the steps above.

Again, the LTPAC Health IT Collaborative welcomes the opportunity to discuss any of these recommendations and look forward to working with CMS to advance interoperability.

Sincerely,

LTPAC Health IT Collaborative

Submitted electronically on behalf of the LTPAC Health IT Collaborative by:
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