September 10, 2018

The Honorable Seema Verma,
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically via: http://www.regulations.gov

RE: CMS-1693-P – Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program.

On behalf of OCHIN, we appreciate the opportunity to comment on the implementation of the proposed changes to the Medicare Program, with revisions to the payment policies, Part B, the Medicaid Shared Savings Program, Quality Payment Program, and Medicaid Promoting Interoperability Program. The Department’s efforts to improve interoperability and promote telehealth and virtual care runs parallel to OCHIN’s goals and has widespread impact on our national healthcare system.

OCHIN is a 501(c)(3) nonprofit community-based health information technology collaborative based in Portland, Oregon. OCHIN receives support from the U.S. Department of Health and Human Services through grants under the Health Resources and Services Administration (HRSA), and is a HRSA-designated Health Center-Controlled Network (HCCN). OCHIN’s mission is to pioneer the use of health information technology in caring for the medically underserved. As such, OCHIN serves community health centers (CHCs), including Federally Qualified Health Centers (FQHCs), rural and school-based health centers, safety-net providers and public health and corrections facilities across the nation. OCHIN’s comments are based on our experiences with the members we serve.

OCHIN appreciates the opportunity to comment, focusing on a few overarching issues: telehealth, reducing provider burden, and improving substance use treatments. We also applaud CMS for their efforts to innovate their interoperability practices and efforts to support the population’s most vulnerable.

**OCHIN supports:**

- OCHIN strongly supports a strong and financially independent primary care system throughout the United States; and
- Using telehealth in its full capacity, especially reaching underserved or uninsured communities addressing the opioid epidemic;
- Increasing and expanding reimbursement and access for eConsult services and virtual care;
- Need for greater research using all federally available claims data sets, such as Medicaid and Medicare, to better understand care and alternative payment models.
• Reducing provider burden by promoting the exchange of healthcare information primarily through the national frameworks, such as Carequality;
• Extending value-based reimbursement opportunities, including for alternative methods of care and for those seeking substance use treatment;

OCHIN will provide specific technical comments on the following areas:

1. Telehealth Services
   a. Section D. Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services (pp 68-89)

2. Opioid & SUDs
   a. Section 5. Expanding the Use of Telehealth under the Bipartisan Budget Act of 2018 (pp 94)
   b. Section d. Scoring Methodology; Section ii. Proposed scoring methodology beginning with the MIPS performance period in 2019 (pp 614)
   c. Section A. Proposed Measure: Query of Prescription Drug Monitoring Program (PDMP) (pp 640)

3. CMS RFIs
   a. Section E. Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs); Section 2. eCQMs Reporting Requirements for EPs under the Medicaid Promoting Interoperability Program for 2019 (pp 462)
   b. Section E. (see above); Section 3. Proposed Revisions to the EHR Reporting Period and eCQM Reporting Period in 2021 for EPs Participating in the Medicaid Promoting Interoperability Program (pp 466)

4. MIPS Policies & Reducing Clinician Burden
   a. Section e. CMS Study on Factors Associated with Reporting Quality Measures; Section iii. Sample Size; Section B. Proposed New Sample Size (pp 599)
   b. Section 5. Promoting Interoperability (PI); Section d. Scoring Methodology; Section ii. Proposed scoring methodology beginning with the MIPS performance period in 2019 (pp 613)

5. Promoting Interoperability Performance Category
   a. Section 5. Promoting Interoperability (PI); Section c. Certification Requirements beginning in 2019 (pp 605)

6. Data Access & Utilization

Telehealth Services

• **eConsult Expansion**: Increasing the use of e-consults expands the reach of specialists as well as mental, behavioral, and primary care providers. We foresee even more success in both primary and specialist treatment when paired with e-consults from behavioral specialists who can assist in identifying other social determinants which may reduce the effectiveness of treatment. This
model can then become more robust by networking in community support programs to help overcome obstacles such as transportation, housing, food security, and even employment. The benefits of expanding eConsult as a standard method of care to the safety net have already been seen in Los Angeles County, where they implemented virtual screening for diabetic retinopathy, which increased annual screening rates by 16%, reduced wait times by 89%, and avoided more than 14,000 unnecessary specialist referrals.\(^1\) eConsults in a Connecticut study also saved almost $500 per patient over a sixth month period in Medicaid costs, as well as reduce the rates of no-shows.\(^2\) OCHIN also strongly suggests increasing funding and reimbursement for eConsult services.

- **Broaden and Expand Coding and Billing**: OCHIN recommends CMS make the coding and billing rules for telehealth (telephone, other telecom devices, remote monitoring, interprofessional consultations, store-and-forward) as simple as possible to follow. Having a set of codes in the Medicare PFS provides accurate compensation to providers assessing patients. Ensuring accurate and simple coding and billing for these consults provides incentive for the clinicians.

- **Avoid Frequency Limitations on Communication Technologies**: OCHIN supports unlimited use of brief communication technology-based services by the same practitioner with the same patient. For those suffering from chronic conditions, running out of electronic communication opportunities could lead to an unnecessary trip to the emergency room, wasting valuable resources which could have otherwise been preserved by this brief communication.

- **Expand Time Limits**: OCHIN also recommends bundling together virtual care and additional telehealth check-ins if the reason for the services is the same. It could be reasonable to expand the time limit surrounding the bundling of services beyond the currently set limits of 7 days and 24 hours to 14 days and 72 hours. Based on the information contained within the EHR, it would likely be possible to discern whether or not the issue the patient contacted the physician about was related to the initial service provided or resulting procedure.

- **Include “Home” in Originating Sites**: In order to expand telehealth and improve the value of care, OCHIN strongly urges CMS to allow for “originating site” to include homes not only of stroke patients, but all patients. Many individuals have long distances to travel in order to get to what CMS would currently consider an “originating site.” By requiring the inclusion of another clinician or other qualified professional for an e-consult when it may not always be necessary, resources are unnecessarily expended or duplicated. A video conference could provide vital information about the status of a patient, allowing the clinician to determine whether the patient should travel to the nearest health center or emergency room or if the ailment doesn’t require professional treatment. Ideally, the patient location would serve as an originating site, whether in a home or another non-clinical location. OCHIN fears creating an arbitrary restriction when patients have virtual care capability consistently at their fingertips through their cell phones, regardless of their location. Allowing patients to receive care without having to travel is

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1 A study published in the Journal of American Medicine in March 2017 found that the technology and referral network led to a significant increase in access to specialty eye care for patients in need of diabetic retinopathy (DR). Results included an 89.2% decrease in wait times for screening and a 16% increase in annual screening rates; further, it was determined that 68.8% of patients did not require a referral for eye care.

2 A study published in the American Journal of Managed Care performed through the Community Health Center and the University of Connecticut Health Center found virtual consults with a specialist resulted in a mean savings of $655 per patient adjusted costs, or when adjusted for non-normality, a mean savings of $466. It also showed improved access to care for underserved patients as well as reducing the no-show rate.
beneficial for both patients and their communities, by avoiding additional costs of travel and lose wages and productivity.

**Opioids and SUDs**

- **Support of New Opioid Measures**: OCHIN supports the new proposed measures for the Query of PDMP and Verify Opioid Treatment Agreement. We further support the requirement to use CEHRT as the sole prescription transmission system to further ensure prescriptions are stored into the patient’s EHR, and to perform a query of the PDMP prior to transmitting a prescription.

- **PDMP Integration into EHR**: OCHIN advocates for integration of opioid tracking systems within the health record to promote their use. When providers are required to use multiple systems to perform their work, their extreme caseload often causes less vital tasks to fall to the wayside. Going outside of the EHR for any service, including an external PDMP, reduces queries because it is an additional step for providers. Were it integrated into the CEHRT, the PDMP would be employed far more consistently. This will inevitably improve patient safety and keep providers accountable as well. OCHIN also advocates for PDMP queries to occur nationally as opposed to state by state to prevent “doctor-shopping” across state or regional boundaries. OCHIN believes use of the Query of PDMP measure using the NCPDP SCRIPT 2017071 standard for e-prescribing can support MIPS eligible clinicians seeking to report on this measure. The NCPDP standard has long been used for e-prescribing and can be implemented as part of the PDMP workflow. If a PDMP system is setup to return drug history data using the NCPDP standard then the clinician’s CEHRT would be able to automatically reconcile the information using the discrete data, displaying it in a format that is streamlined with all other clinical information and allows for clinical decision support tools within the CEHRT to act on this data.

- **Incentivize Non-Opioid Alternatives**: Non-opioid alternatives for pain treatment and management should include non-medication modalities such as physical therapy, massage, acupuncture, cognitive behavioral therapy, injections or nerve blocks, and even more high-tech treatments like radio waves and electric signals. Understanding that it is easier and more time-efficient to prescribe opioids, reimbursement should provide incentives to providers to recommend non-medication therapies.

**MIPS Policies & Reducing Clinician Burden**

- **Align Medicaid and Medicare Reporting Measures**: OCHIN supports aligning Medicaid PI measures with MIPS PI measures, and reducing reporting measures on Medicare providers as well as on Medicaid providers. OCHIN is concerned that an increased burden on Medicaid provider reporting will increase reporting costs and discourage participation in the program, reducing the safety net and disproportionately affecting the most vulnerable population.

- **E-Specified CHIP and Core Set Measures**: OCHIN supports inclusion of Adult and Child Core Set measures for Medicaid EPs. OCHIN supports state Medicaid programs being in alignment with national programs. The eCQM requires stabilization and alignment with other national federal programs.

- **2021 Medicaid PI Reporting Period**: OCHIN believes that as long as there are reporting requirements, maximizing the flexibility in reporting will reduce burden.
• **Reduce Clinician Burden:** OCHIN is in full agreement to reduce clinician burden of documentation as outlined in the proposed rules. For very complex visits, an additional code should be allowed to have the reimbursement more accurately reflect the service provided. OCHIN also recommends incorporating and distinguishing MIPS eligible clinicians also reporting for Medicaid PI, in multiple states, to analyze factors associated with dual reporting. Further, OCHIN recommends incorporating and distinguishing MIPS eligible clinicians also reporting for Medicaid PI, in multiple states, to analyze factors associated with dual reporting.

**Promoting Interoperability Performance Category**

• **Minimum Standard 2015 Requirement:** OCHIN strongly agrees that setting a minimum standard of the 2015 Edition certification criteria for EHR technology. OCHIN sees the value of the 2015 minimum for interoperability purposes, and suggests CMS consider pushing further for more up-to-date versions of CEHRT in the near future. As stated in the proposed rule, 2015 CEHRT edition increases data exchange – a critical piece for growing the telehealth movement and interoperability. Staying current is necessary in the case of national emergencies and the benefits outweigh the upgrade costs. OCHIN recommends that CMS ensures providers meet the minimum 2015 certification standards for EHRs that support the National Interoperability Framework such as Carequality, or, at minimum, E-Health Exchange. To reduce the financial burden, OCHIN recommends encouraging providers to enable the national framework models wherever possible within their electronic health record (EHR) and use existing funds to support any need for technical assistance to the provider.

**Data Access and Utilization**

• **Increase Access to Federal Data Sets:** Federal data sets such as Medicaid and Medicare should become more easily available to approved research entities to increase analysis of these data sets. Such analysis will increase insight into current value of care, the additional costs of high-risk patients, and the potential of alternative payment models. OCHIN supports an increased flow of data to provide insight prior to making extensive policy changes.

We thank you for your time and consideration of our comments on the 2019 Physician Fee Schedule Proposed Rule. Please contact Jennifer Stoll at stollj@ochin.org should you have any questions.

Sincerely,

Jennifer Stoll
VP, Government Affairs and Public Relations